Harmon Memorial Hospital

Division: **CBO**

Effective Date: 07/01/2012

POLICY TITLE: Billing Practice

POLICY STATEMENT: This policy outlines the process to be followed by the Central Billing Office (CBO) in the billing of all claims. In accordance with the national billing practices, the CBO recognizes that claims submitted to third parties must comply with all federal, state and local government agencies regulations in billing for services provided.

PROCEDURES

Restrictions

The Biller will not

- Make diagnostic and/or procedure code changes and/or manipulate codes on the UB04 claim form in order to get a claim paid (All coding issues will be resolved by Health Information Management in collaboration with the appropriate department manager.)
- Write-off any charges to Medicare, Medicaid, or Tricare/Champus without management review and written approval.

Requirements

The Biller will

- Be thoroughly knowledgeable of and adhere to all policies and practices relating to proper completion of UB04 claims.
- Be thoroughly knowledgeable of and adhere to policies and procedures related to electronic claims submission.
- Have a thorough understanding of the claims administration process regarding medical documentation, coding, billing and the relationship between Health Information Management and the CBO.
- Be thoroughly knowledgeable of all claims submission rules of the Medicare fiscal intermediary or other individual carriers.
- Understand the Medicare Fraud and Abuse Guidelines and penalties for submitting false claims.
- Understand that the Biller's work will be reviewed periodically for compliance with the hospital's policy on business practices, as well as adherence with the CBO policies and procedures.
- Report any suspected or known wrong-doing to the CBO Manager or Compliance Officer, in accordance with the Hospital's established policy.

Billing Guidelines

1. The CBO Manager has implemented a process validating that all accounts are billed in a timely manner. The process includes management reports depicting daily, weekly and monthly volumes of claims processed, number of rebilled claims in the period and number of claims where billing has been delayed.

   A. Primary electronic Medicare and Medicaid claims are billed daily
   B. Commercial electronic claims are processed daily, when possible. Only on large claim days are claims processed the next business day, when necessary.
   C. All paper claims are printed and sent daily, when possible. Many paper claims require attached records and are sent within 3 business days when records are scanned and available for printing. Follow-up with hospital staff for non-scanned records is performed in a timely manner, in order to get paper claims filed weekly.

2. The Hospital should implement an Unbilled/Uncoded report that depicts the numbers of accounts, aging of the accounts and the dollar value of the accounts. This report should be compiled and given to the hospital Administrator on a weekly basis and at the end of the month.

3. The hospital designated staff member communicates with the CBO Biller when late charges are being entered by the hospital coding or charge entry staff. The Biller sends electronically corrected claims to Medicare and Medicaid, as necessary, for all OP late charges. The Commercial corrected claims are mostly filed via paper claims. The Biller reports any necessary adjustments regarding the late charges on DRG paid IP claims to the CBO Manager for adjustments to be applied. Medicare IP claims are adjusted on-line for cost reporting purposes.

Department Approval: _____ Date: _____\

Administrative Approval:_____ Date: _____

Replaces Policy: _____ Original Date _____

CAH Reference: _____ Dated _____

State Licensing: _____ Dated _____

Date Reviewed	Date Revised	Supervisor Initials	Comments