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	EFFECTIVE DATE: 8/15/00	NUMBER: 9042
	ORIGINATOR: Corporate Compliance Officer	
ORGANIZATIONAL POLICY CHARGING, BILLING AND CLAIMS	CONCURRENCE: Chair, Corporate Compliance Committee Chief Financial Officer Director of Patient Financial Services	
	APPROVAL: CEO/PRESIDENT	

PURPOSE OF POLICY

It is the policy of Ellis Hospital, its affiliates and contractors to comply with all Federal and State charge, billing, and claims payment laws. When claiming payment for Hospital or professional services, the Hospital has an obligation to its patients, third party payors and the state and federal governments to exercise diligence, care and integrity. The right to bill Medicare and Medicaid programs, conferred through the award of a provider or supplier number, carries a responsibility that may not be abused. The Hospital is committed to maintaining the accuracy of every claim it processes and submits.

Ellis Hospital recognizes that many people, throughout the Hospital have responsibility for the processes that lead to the billing of a claim. The scope of a "Charging and Billing" policy includes the processes that lead up to the charging and billing of the claim as well as the claim submission itself. The full spectrum of these processes include the documentation of a patient need, a written order, (charge/credit) order entry functions, charge/credit data entry functions, medical record documentation, diagnosis and procedure coding, claim submission, and record retention.

SCOPE

This policy applies to all employees and physicians at Ellis Hospital.

DEFINITION OF TERMS AND EXAMPLES OF MOST COMMON AUDIT FINDINGS:

False Claim: Any request made to a payor for services that were not rendered and documented as portrayed on the billing document. It can include any claim for payment of services for which an organization is not entitled to bill the insurance carrier or patient. False charges, inadequate documentation or failure to keep documentation that supports legitimate services, are examples of procedural issues that can lead to a false claim.

False Charge: Causing a charge to be posted to an account that is not medically necessary, not supported by written documentation in the medical record, or failing to credit items that were ordered, but not performed.

Examples of False Claims and False Charging Practices: False billing is a serious offense. Medicare and Medicaid rules prohibit knowingly and willfully making or causing to be made any false statement or representation of a material fact in an application for benefits or payment. It

is also unlawful to conceal or fail to disclose the occurrence of an event affecting the right to payment with the intent to secure payment that is not due. Examples of false claims include:

- A. Claiming reimbursement for services that have not been rendered. This includes posting charges or failing to credit services not performed, and ordering services that are not properly documented.
- B. Filing duplicate claims.
- C. "Up-coding" to more complex procedures than were actually performed.
- D. Including inappropriate or inaccurate costs on Hospital cost reports.
- E. Falsely indicating that a particular health care professional attended a procedure or that services were otherwise rendered in a manner they were not.
- F. Charging/Billing for a length of stay beyond what is medically necessary.
- G. Charging or Billing for services or for items that are not medically necessary not ordered properly, or not documented appropriately.
- H. Charging Medicare/Medicaid for patient convenience items
- I. Inaccurately representing (and charging) for items or services precluded from coverage by the payor such as screening services.
- J. Failing to credit services that were not performed.
- K. Failing to retain supporting medical or financial documentation
- L. Submitting claims with false information such as diagnosis, procedure codes or inaccurate physician information.

EMPLOYEE RESPONSIBILITIES:

Individuals involved in these processes and their supervisors are expected to monitor compliance with applicable documentation rules. Any false, inaccurate, or questionable orders, charges/credits, omissions or inaccurate claims should be reported immediately to a supervisor, Director or the Corporate Compliance Officer.

In addition, cooperation is expected with audits by the Internal Auditor and other designated individuals. Departments will also be expected to receive yearly in-service education on compliance issues.

PENALTIES:

A provider or supplier who violates the Federal False Claims Act is guilty of a felony, and may be subject to fines of up to \$ 25,000 per offense, imprisonment for up to five years, or both. Other persons guilty of false claims may face fines of up to \$ 10,000 per offense, imprisonment for up to one year, or both. In addition to the criminal penalties, the Federal False Claims Act permits substantial civil monetary penalties against any person who submits false claims. The act provides a penalty of triple damages as well as fines up to \$ 10,000 for each false claim

submitted. The person (as well as the Hospital) may be excluded from participation in the Medicare and Medicaid programs. Violations of the assignment and reassignment rules are misdemeanors carrying fines up to \$ 2,000 and imprisonment of up to six months, or both. In addition to these federal penalties there may also be state laws and penalties.

Numerous other federal laws prohibit false statements or inadequate disclosure to the government and mandate exclusion from the Medicare and Medicaid programs. For instance, neither the Hospital nor its agents are permitted to make, or induce others to make, false statements in connection with the Hospital's Medicare certification. Persons doing so are guilty of a felony and may be subject to fines up to \$ 25,000 and imprisonment for up to five years. The hospital or individual health care providers will be excluded from the Medicare and Medicaid programs for at least five years if convicted of a Medicare or Medicaid related crime. Medicare and Medicaid exclusion may result if the Hospital or provider is convicted of fraud, theft, embezzlement, or other financial misconduct in connection with any government-financed program.

It is illegal to make any false statement to the federal government, including statements on Medicare or Medicaid claim forms. It is illegal to use the United States Mail in a scheme to defraud the government. Any agreement between two or more people to submit false claims may be prosecuted as a conspiracy to defraud the government.

The hospital promotes full compliance with each of the relevant laws by maintaining a strict policy of ethics, integrity, and accuracy in all of its financial dealings. Each employee and professional, including outside consultants, who is involved in submitting charges, preparing claims, billing, and documenting services is expected to maintain the highest standards of personal, professional and institutional responsibility.

NEW YORK STATE LAW

New York State Social Services Law, Section 145-B likewise prohibits knowingly, by means of a false statement or representation, or by other fraudulent scheme or device, attempting to obtain benefits or payments. Violations of State Law may be punishable by civil damages equal to three times the amount by which any figure is falsely overstated or five thousand dollars (\$5,000) whichever is greater or monetary penalty not to exceed two thousand dollars (\$2,000) to the Medical Assistance Program.

EXHIBITS

REFERENCES

- A. Organizational Policy #3452: "Work Rules and Disciplinary Actions".
- B. Organizational Policy #5347: "Records Management".
- C. Organizational Policy #7164: "Institutional Transfers".
- D. Organizational Policy #7282: "Observation Status".
- E. Organizational Policy #7320: "Prospective Payment System Leave of Absence".

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