

Here is a tool to help you become in compliance with medical billing rules and regulations, both for governmental and private payors. If you do not have a policy or procedure for any of the items, be sure to work with your Compliance Office to develop them. Place the answers to each of the topics in a binder and you have the basis of your Compliance Program.

RISK ASSESSMENT

Briefly describe any policies and procedures you may have in place regarding the following:

1. To prevent billing for items or services not actually rendered. {Billing for services not actually rendered involves submitting a claim that represents that the provider performed a service all or part of which was simply not performed. }
2. To prevent billing for items or services not actually documented. {Billing for services not actually documented involves submitting a claim that cannot be substantiated in the documentation. }
3. To prevent providing and billing for medically unnecessary services. {A medically unnecessary service is one which is not warranted by the patient's current and documented medical condition, or which is not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. }
4. To prevent upcoding. {Upcoding is the practice of using a billing code that provides a higher payment rate than the billing code of the service actually furnished to the patient. }
5. To prevent inappropriate balance billing. {Inappropriate balance billing is the practice of billing the patient the difference between the total provider charges and the contracted allowable payment (for example, billing the patient the difference between provider charges and the Medicare allowed amount or limiting charges. }
6. To prevent duplicate billing. {Duplicate billing occurs when more than one claim is submitted for the same service or when the bill is submitted to more than one primary payor at the same time. }
7. To prevent inadequate resolution of overpayments. {An overpayment is an improper or excessive payment made as a result of billing or claims processing error, for which a timely and accurate refund is owed by the provider. }

8. To prevent unbundling. {Unbundling is submitting bills in a fragmented fashion to maximize the reimbursement of tests or procedures that are required to be billed together, or using separate billing codes for services that have an aggregate billing code. }
9. To ensure the integrity of billing information. {For example, records can be easily located and accessed, computer systems are regularly backed up, records are well organized and easily retrieved. }
10. To prevent the use of computer software programs or other methods that encourage billing personnel to enter data in fields indicating services were rendered though actually not performed or documented.
11. To ensure the confidentiality and privacy of financial, medical, personnel and other sensitive information and to ensure confidentiality with both electronic and hard-copy documents.
12. To prevent misuse of provider identification numbers.
13. To follow the provisions of reassignment of benefits. {These provisions rule who may receive payments due to a provider, for example whether a group may receive payments for a specific provider}.
14. To properly use CPT modifiers.
15. To prevent incentives that violate the anti-kickback statute.
16. To prevent violations of the Stark physician self-referral law.
17. To prevent routine waivers of copayments and deductibles and to avoid “insurance only” arrangements.
18. To proportionally apply discounts and professional courtesy to patients and payors.
19. To ensure that procedure and diagnosis coding are based on medical documentation.
20. To ensure that all services are properly and appropriately documented.
21. To avoid the employment of sanctioned individuals.

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