TITLE: Charge Posting and Billing Compliance Process

POLICY/PURPOSE:

As part of the University of Florida College of Medicine – Jacksonville Billing Compliance Plan, prospective reviews of professional charges for government payers will be performed.

As an organization, we must ensure documentation supports the service billed. This includes application of Teaching Physician rules, Evaluation and Management guidelines, sound CPT-4 and ICD-10-CM coding and carrier specific medical policies.

This policy affects ALL charges for Medicare/Medicaid/TriCare patients rendered in ALL locations of service, ALL billing areas, and ALL Business Groups.

Business Groups have Work Queues designed to hold charges until the charges can be reviewed for compliance or they receive charges directly through the charge router (e.g., Radiology). Charge entry and documentation review are performed on Medicare/Medicaid/TriCare patient charges in those Work Queues or via the charge router.

The designated party to review the documentation and charges will be determined at the Business Group level (the "Designee"). The Designee must be knowledgeable in medical coding and government billing regulations.

DEFINITIONS:

EOB – Explanation of Benefits. A statement from the patient's health insurance plan describing what costs it will cover for medical care or products the patient received. An EOB is generated when a claim is filed and processed by the patient's health insurance plan. Alternate names are Remittance Voucher and Explanation of Medicare Benefits (EOMB).

PROCEDURE:

A. Medicare/Medicaid/TriCare Payer identified prior to charge posting:

1. Regardless of whether Medicare/Medicaid/TriCare is the primary, secondary, or tertiary payer, the charge must be reviewed to ensure compliance requirements are met PRIOR to billing. To ensure this occurs, the charge must be routed to a Business Group's Work Queue. The Designee performs documentation and

charge entry review on Medicare/Medicaid/TriCare patient charges in this Work Queue.

2. Charges received directly via the charge router are coded and reviewed for compliance prior to releasing the charge. As such, there is not a "Compliant" field in the charge entry screen to populate.

    a. If the charge is compliant, the charge will be released for processing (assuming all other rules and edits have been satisfied).

    b. If the Designee determines the charge is not compliant with the particular payer's guidelines, the CPT codes will be deleted and internal procedure code "B0459" (non-compliant service) will be reported.

3. For charges that enter a Work Queue, there is a "Compliant?" field in the charge entry screen that must be filled in with either a "Yes" or "No" response to indicate whether the charge is compliant with the particular payer's guidelines.

    a. If the charge is compliant, the "Compliant?" field is to be populated with the "Yes" response. That charge will then be released for processing (assuming all other rules and edits have been satisfied).

    b. If the Designee determines the charge is not compliant with the particular payer's guidelines, the Designee will populate the "Compliant?" field in the charge entry screen with a "No" response. The CPT codes will be deleted and internal procedure code "B0459" (non-compliant service) will be entered. The services lost are entered in the comments section.

B. Medicare/Medicaid/TriCare identified after charge posting:

1. If a charge was not previously identified as Medicare, Medicaid or TriCare (primary, secondary, or tertiary) and now needs to be billed to one of these benefit plans (such as through the retro-adjudication activity), the charge should NEVER automatically be changed directly to a Medicare/Medicaid/TriCare benefit plan. The charge(s) must be reviewed by the Designee to ensure compliance guidelines are met PRIOR to billing. These charges will go to a Work Queue for review.

2. If there is a "Compliant?" field in the charge entry screen, that field must be populated with either a "Yes" or "No" response to indicate whether or not the charge is compliant with the particular payer's guidelines.

    a. If the response is "Yes," that charge will be released for processing (assuming all other rules and edits have been satisfied).

    b. If the Designee determines the charge is not compliant with the particular payer's guidelines, the Designee will populate the "Compliant?" field in the charge entry screen with a "No" response and follow the procedure in either section C or D, dependent on primary payer payment.

C. No Payment by Primary Insurer and Charge Not Compliant:

1. Designee determines the charge is not compliant with the particular payer's guidelines.

    a. If there has been not been a payment by a primary insurer, a charge correction shall be made to reflect any corrections to the charge based upon the review by the Designee, if the charge has been posted to the patient account.

    b. If the charge is still in the Pre-AR area, the CPT codes will be deleted and internal procedure code "B0459" (non-compliant service) will be entered. The services lost are entered in the comments section.

D. Payment Made by Primary Insurer and Charge Not Compliant:

1. Designee determines the charge is not compliant with the particular payer's guidelines.

    a. If a payment by a primary insurer has already been made, and the charge if found to be non-billable due to lack of or insufficient teaching physician note, the balance must be written off with adjustment code "5271 " (compliance non-audit). The Billing Refund Analyst in the UFJPI Clinical Data Quality Department will be responsible for processing any necessary refunds.

b. If the charge is found to be non-billable because there is insufficient documentation to substantiate the services in general, the charge must be backed off the system and any primary insurer payment must be refunded.

c. If a correction is identified that impacts core aspects of the charge, the charge must be corrected, and the primary insurer should be notified of the change (possible adjustment, review refund, or void may be necessary). Once a corrected EOB is received from the primary insurer, Medicare/Medicaid/TriCare could be filed with the corrected EOB. Core aspects of a charge include but are not limited to, discrepancies in the procedure code type, level of service, date of service, provider of service, location of service, or modifiers impacting reimbursement.

2. It is important to note, particularly on automated crossover claims, that secondary or supplemental benefits may not be coordinated correctly because charge information on the primary EOB will not match the corrected charge(s). Caution must be used in these instances to avoid inconsistencies between the primary and secondary payer EOB.

REFERENCES:

APPROVED BY:
UFJPI Policy Review Committee