VAN BUREN COMMUNITY MENTAL HEALTH AUTHORITY
POLICIES & PROCEDURES

Title: Billing and Claims Submission
Number: III.17
Originated: 12/04/04
Approved By: Executive Team
Revised: 04/25/06, 10/23/15

DIRECTIVE:

Van Buren Community Mental Health Authority requires compliance with all laws and regulations pertaining to claims submission and reimbursement under Medicare, Medicaid and all other third party payors.

BILLING RULES:

1. To ensure that professional services are properly billed, all documentation must be completed in an accurate, organized, legal and timely manner. Clinical staff must only report services when the clinical documentation supports the services being submitted for billing. Providing staff will only submit claims when the clinical documentation supports the authorized services being billed. The documentation should accurately reflect:

    a. Date, start time and duration of the service
    b. Individual providing the service and his/her credentials
    c. Diagnosis that supports the service provided
    d. Supervising professional when indicated
    e. Signatures, credentials, and date

2. Bill only for service actually rendered. Claims will only be submitted to payors when there is documentation in the electronic record that supports services being billed.

3. Claims will only be submitted for services that Van Buren Community Mental Health Authority believes are medically necessary and were ordered by a physician or other appropriately licensed practitioner. These services must be “reasonable and necessary” according to the standards for reimbursement set forth in applicable statutes and regulations.

4. Claims will be submitted using the appropriate billing codes identified for each individual payor. Clerical, Reimbursement, and Compliance staff need to work together to seek clarification when in doubt of a billing or coding procedure. In the event an answer cannot be obtained internally, contacting outside agencies must be coordinated with the Corporate Compliance Officer. The inquiry and answer obtained must be properly documented and a copy sent to the Chief Executive Officer.

5. Only an appropriate licensed professional can determine the clinical diagnosis operating within the scope of their practice and licensing according to the Michigan Public Health Code. They will assign appropriate diagnosis for each service. Claims will be submitted using the appropriate diagnosis for the service rendered.

6. Refund all credit balances in a timely and appropriate manner.

7. Do not routinely waive co-payments and deductibles. Customers must be billed for co-payments and deductibles within the scope of their financial responsibility as determined pursuant to Michigan State law. The customer should only be billed for the portion determined by the Reimbursement Procedure and "Ability to Pay".

8. Do not bill for non-covered services. Customers who have Medicare cannot be billed for services or supplies not covered unless they are informed prior to the services rendered.

BILLING DISCREPANCIES:

1. Any claim with a reasonable suspicion of fraud or abuse should be reported to the Corporate Compliance Officer.

2. The Corporate Compliance Officer will investigate the suspected discrepancy and if necessary take corrective action including the development of steps to prevent its recurrence.

3. Any overpayments received will be repaid, per payor requirements.

Related Procedure:

I.06.12 Service Error & Exception Reports