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

DIRECTIVE:

Van Buren Community Mental Health Authority requires strict and complete full compliance with all relevant billing requirements by requiring all personnel involved in billings and claims submission are expected to maintain high ethical standards and a strong knowledge of all laws and regulations related to the billing functions.

GENERAL GUIDELINES:

1. All personnel who are involved in any aspect of the Van Buren Community Mental Health Authority's billing and claim activities will be held to a high standard with respect to knowledge and adhering to the requirements and standards for participation in the health care industry, including but not limited to, all rules and regulations pertaining to claims submission and reimbursement under Medicare, Medicaid and all other third party payors.

2. All clinical staff will be properly licensed, certified and/or credentialed by the appropriate governing body.

3. Accurate billings and claims submission requires cooperation and effective communication between members of billing and clinical staff. An effective billing program requires that all staff involved in the customer care process be diligent with respect to proper documentation. Proper documentation will ensure that claims are submitted correctly.

4. Staff members are responsible for seeking 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. To ensure that all 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 services being billed. The documentation should accurately reflect:

- Start time and duration of the service
- Individual providing the service and his/her credentials
- Diagnosis that supports the service provided
- Supervising professional when indicated
- Signatures, credentials, and date

BILLING RULES:

1. Bill only for service actually rendered. Claims will only be submitted to payors when there is documentation that supports services being billed.

2. Bill only for medically necessary services. 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.

3. Check all billing codes. Claims will be submitted using the appropriate billing codes identified for each individual payor.

4. Assign appropriate diagnosis for each service. Claims will be submitted using the appropriate diagnosis for the service rendered. Only an appropriately licensed professional can determine the clinical diagnosis.

5. Ensure all claims are properly bundled. Claims will be submitted using the appropriate billing code when providing bundled services. Check all claims to make sure that no duplication of codes are present for multiple services.

6. Ensure that no duplicate billing occurs. Check all claims to ensure that no more than one claim is submitted per service.

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

8. 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".

9. 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.

10. Do not submit charges for service unless there is a current Treatment Plan and Assessment. Charges for services should not be submitted for billing unless there is

a current treatment plan and assessment if required. This also requires the Van Buren Community Mental Health Authority bill only for services supported by a treatment goal.

BILLING DISCREPANCIES:

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

2. Discrepancies Review. 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. Refunding of overpayments. Any overpayments received will be repaid within sixty (60) days to the appropriate payor with interest, if applicable.