Policies and Procedures: Corporate

This policy is in effect for Children's Health System (CHS) and its subsidiaries.

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SUBJECT: **CODING AND BILLING COMPLIANCE, FALSE CLAIM PREVENTION AND COMPLIANCE WITH THE FEDERAL DEFICIT REDUCTION ACT OF 2005**

POLICY: It is the policy of Children's Hospital of The King's Daughters Health System (CHKDHS) to comply with all billing, reimbursement and reporting requirements at the federal, state and payer levels. It is also the policy of CHKDHS to provide notice to employees and contracted vendors about the federal False Claims Act, the Virginia Fraud Against Taxpayers Act and the North Carolina Medical Assistance Provider False Claims Act, as required under the federal Deficit Reduction Act of 2005, § 6032.

BACKGROUND: Children's Health System, Inc. (CHS) and its subsidiaries have an obligation to process and submit accurate claims. Third party carriers require certain codes for the billing of hospital charges (Revenue, CPT, and HCPCS codes). Each department works in conjunction with the Managed Care, Health Information Management (HIM), Information Services (IS), and Patient Financial Services (PFS) departments for timely and accurate billing of claims.

The billing and claim reimbursement function is carried out through various health system personnel. Accurate billing and claims submission requires cooperation and effective communication between members of billing staff and clinical staff members. An effective billing program requires all persons involved in the patient care process (i.e., clinical or administrative staff) be diligent with respect to proper documentation. It is essential all clinical staff document

physician and other professional services in an accurate, organized, legible and timely manner and in accordance with any Medical Staff policy related to documentation and maintenance of patient medical records to ensure services are properly billed. All personnel are expected to perform clinical billing and reimbursement functions in accordance with all applicable rules, including but not limited to, Medicare and Medicaid reimbursement statutes and regulations.

It is the policy of CHKDHS to promote full compliance with all relevant billing and claim reimbursement requirements by requiring all personnel involved in billing and claims submission to maintain high ethical standards and a strong knowledge of all laws and regulations related to the billing function. All persons involved in any aspect of CHKDHS' billing and claims reimbursement activities will be held to a high standard with respect to knowing 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 the Medicare and Medicaid programs. In addition, all such persons will be properly credentialed by the appropriate professional organization.

CHKDHS submits claims only when there is appropriate clinical documentation to fully support the claim and when the documentation fulfills the applicable maintenance requirements for such documentation in accordance with the *Corporate Policy #C3405, Record Retention*. The documentation should include patient medical records and must (1) identify the length of time spent conducting the service, (2) identify the individual providing the service, (3) where appropriate, identify the person(s) supervising the provider of the service and (4) fully support services rendered as well as codes and diagnoses to be utilized for each claim.

Failure to document patient care properly may result in the improper submission of claims by the health system such as when:

- the admitting or registration personnel fails to give a Medicare beneficiary the notices and information required by the program;
- clinical staff fails to document the time spent, services provided and materials used in the patient's care;
- an ancillary department misidentifies a service;
- data entry personnel applies a charge to the wrong patient account; or
- the Health Information Management (HIM) Department incorrectly applies the code.

The False Claims Act prohibits a person from submitting claims or making a false record or statement in order to secure payment of a false or fraudulent claim by the federal government. Faulty billing practices can have very serious consequences for the Health System and its employees, up to and including prosecution under the Federal False Claims Act and other state and federal laws.

Some common types of false claims that may result from poor documentation or coding practices are (1) billing for items or services not actually rendered, (2) providing medically unnecessary services, (3) upcoding, and (4) unbundling. Additional examples of false claims are described on Exhibit A attached hereto.

The Federal Deficit Reduction Act of 2005, § 6032 requires CHKDHS to provide detailed information to its employees and contracted vendors involved in CHKDHS billing and reimbursement functions about the Federal False Claims Act, the Virginia Fraud Against Taxpayers Act and the North Carolina Medical

Assistance Provider False Claims Act. This policy documents the content of and procedures for providing such information to employees and contracted vendors as part of CHKDHS' efforts to prevent false claims.

See related *Corporate Policy #C5411, Corporate Compliance Program*, for CHKDHS' internal policies and procedures for detecting and preventing fraud, waste, and abuse in the CHKDHS billing and reimbursement functions as required under the Federal Deficit Reduction Act of 2005.

PROCEDURE:

A. **Department responsibilities:** The following outlines the responsibilities of each specified area/department.
   1. Each patient care department clinical Director and/or designated staff should attend in-services on CPT/HCPCS coding provided by the HIM Department. Staff members new to the process are required to attend a CPT/HCPCS in-service. It is recommended after the initial training, all appropriate staff attend in-services periodically and, as necessary, to address changes in reimbursement rules and regulations.
   2. All newly created charges must be assigned CPT or HCPCS codes whenever appropriate. All additions or changes to the existing billing codes associated with charges in the Charge Description Master File must be approved in writing by the patient care department clinical Director and the Director of HIM or Patient Account Manager.
   3. It is the responsibility for each patient care clinical department director and/or designated staff to review at least annually his/her departmental CDM File to ensure that all codes are current and accurate. This process would typically begin during January and must be completed by March 15. To assist in that process, the Patient Financial Services (PFS) Department will provide each department with a listing of their CDMs and the associated CPT/HCPCS codes and the most current edition of newly created, changed and deleted codes. The HIM Department will coordinate the dates of the periodic CPT/HCPCS in-services to occur during this annual review period when possible. As the need arises for training in the hospital departments during the periods between the periodic in-service programs, it will be the responsibility of the department Directors to make arrangements with the HIM Department to schedule the necessary in-service programs.

B. The following general rules apply to any personnel involved in billing and/or claims reimbursement.
   1. All facility/hospital claims are processed through a bill scrubber product (nThrive, Claims Management). Edits are updated twice a week as changes are published. All claims are subject to state, federal and payer billing guidelines and edits in this review.
   2. Claims submitted for the services of teaching physicians shall comply with the following:
      a. Only services actually provided are billed.
      b. Every physician who provides or supervises the provision of services to a patient has verified the correct documentation of the services that were rendered.
      c. The appropriate documentation is placed in the patient's medical record and is signed by the physician who provided or supervised the services. In cases where the physician is providing evaluation and management services, a patient's medical record includes appropriate documentation of the applicable key components of the evaluation and management services provided or supervised by the physician; and the physician documents his/her presence during the key portion of any service or procedure for which payment is sought.
   3. Verify all claims are submitted in accordance with the DRG and the One-Day Payment Window Rule for children's hospitals.
      a. Identify all outpatient services that may not be billed separately from an inpatient stay occurring within the one-day period immediately preceding the date of the patient's admission to the hospital.

4. Verify claims are submitted only for services provided by CHS or "under arrangements" with other suppliers/providers.
5. Report patient transfers accurately. Coding/HIM is responsible for ensuring the correct discharge status.
6. Do not submit claims for improperly referred patients.
    a. If CHKDHS becomes aware of any contracts or arrangements which might violate the Anti-Kickback Statute, Stark Law or other anti-referral law, the billing department should be advised immediately.
    b. Patients who may have received services due to an improper referral arrangement should be identified and no claims for reimbursement from Medicare or Medicaid should be sought for the treatment of such patients.
7. Review current billing policies and procedures to ensure they reflect current operations and are consistent with current regulatory and payer guidance.
8. Refund all credit balances in a timely, accurate, and appropriate manner in accordance with applicable law and federal program requirements. See *Corporate* P*olicy #C5411, Corporate Compliance Program*, for additional requirements regarding the refunding of credit balances.
9. Discovery of billing errors.
    a. If a billing error is discovered, the error should be immediately reported to the manager of the billing department, hospital or physician, respectively, or the CHS Compliance Officer.
    b. Should any such report be made to the Billing Manager, the Billing Manager must report potential billing errors to the Compliance Officer.
    c. Appropriate steps will be taken to investigate the cause of the error and to prevent its reoccurrence.
    d. Any identified overpayments as defined in the False Claims Act, received as a result of such billing error, will be promptly refunded to the appropriate payor (with interest, if appropriate) within the applicable required timeline.

C. Staff should seek clarification from management regarding billing and coding practice when questions arise. If necessary, management will escalate the question, first to the respective billing department Director, who may coordinate a response through Compliance Department, Legal and/or outside advisors. The inquiry and the answer obtained thereto should be properly documented in writing and made available to the appropriate billing department and the CHS Compliance Officer for retention in compliance with *Corporate Policy # C3405, Record Retention*.

D. **Government Required Notices under the Deficit Reduction Act of 2005, § 6032.**
1. Initial Employee Notice. The Employee Notice attached to this policy as Exhibit B shall be posted on KDNet immediately following the effective date of this policy and a reminder shall be published for four (4) consecutive weeks following the effective date of this policy in the CHKDHS Weekly Update alerting employees of the Employee Notice posting on KDNET.
2. Ongoing Employee Notice. The Employee Notice information set forth in Exhibit B shall remain posted on KDNET at all times and shall be incorporated into the CHKDHS Employee Handbook which is received and signed by all employees. Additional training addressing false claims activity will be incorporated into the existing CHKDHS computer-based training course required to be completed annually by all CHKDHS employees.
3. Initial Contracted Vendor Notice. Effective immediately after the effective date of this policy, the CHKDHS Legal Department will distribute the contracted vendor policy attached as Exhibit C to any existing CHKDHS contractor, subcontractor, agent of other person which or who, on behalf of CHKDHS, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by CHKDHS.

4. Ongoing Contracted Vendor Notice. The CHKDHS Legal Department will incorporate appropriate language into all new contracts entered into between CHKDHS and any

contractor, subcontractor, agent of other person which or who, on behalf of CHKDHS, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by CHKDHS that addresses obligations regarding false claims activity.

All violations or suspected violations of this policy, the CHKDHS Compliance Program, or the Conditions of Participation, must be reported in accordance with *Corporate Policy # C5411, Corporate Compliance Program*, and may require corrective action up to and including termination.

E. **References**

1. If there are coding and billing questions specific to Never Events and Hospital Acquired Conditions (HACs), refer to *Hospital Policy # H5443, Never Events and Hospital Acquired Conditions (HACs).*
2. If there are cost report questions, refer to *Hospital Policy # H5406, Cost Report Compliance*.
3. If there are questions regarding any physician arrangement, refer to *Corporate Policy # C5434, Physician Arrangements and Fair Market Value*.
4. If there are questions regarding reporting compliance concerns, refer to *Corporate Policy # C5411, Corporate Compliance Program*.

EXHIBIT A
FALSE CLAIM EXAMPLES

Examples of false claims include, but are not limited to, the following:

1. Billing for Items or Services Not Actually Rendered. Billing services not actually rendered involves submitting a claim which represents that the provider performed a service, all or part of which was not really performed.

2. Providing Medically Unnecessary Services. A claim requesting payment for medically unnecessary services intentionally seeks reimbursement for a service that is not warranted by the patient's current and documented medical condition.

3. Upcoding. Upcoding is the term for the practice of billing Medicare or Medicaid using a billing code which provides a higher payment rate than the billing code intended to be used for that item or service.

4. Diagnosis Related Group (DRG) Creep. DRG creep is the practice of billing Medicare or Medicaid using a DRG code that provides a higher payment rate than the DRG code intended to be used for that item or service. For example, the government has instituted a nationwide investigation called the Pneumonia DRG Upcoding Project to identify hospitals that falsify the diagnosis related group on claims from viral to bacteria pneumonia.

5. Waiver of Coinsurance and Deductibles. In addition to qualifying as a false claim, waiving coinsurance, copayments or deductibles may also be unlawful because the practice may result in violations of the anti-kickback statute and excessive utilization of items and services paid for by federal programs like Medicare and Medicaid.

6. Unbundling. Unbundling is the practice by which providers submit bills "piecemeal" to maximize reimbursement rather than submitting the procedure or product as a whole at a lower rate. For example, a hospital that unbundles blood chemistry tests when using automated equipment and then bills for each analysis separately, or bills for an automated test in addition to several of the analyses separately.

7. Fragmentation. Fragmentation is the practice of billing separately for services in cases where global billing is available, but would result in a lower payment rate.

8. Filing False Costs Reports. Falsified cost reports may result from a number of erroneous cost reporting practices including:

    - Incorrectly apportioning costs on costs reports;
    - Including costs of non-covered services, supplies or equipment in allowable costs;
    - Billing Medicare for costs not incurred or that were attributable to non-program activities, other enterprises or personal expenses;
    - Repeatedly including unallowable cost items on a provider's cost report except for purposes of establishing a basis for appeal;
    - Manipulating statistics to obtain additional payments such as increasing the square footage in the outpatient areas to maximize payments;
    - Claiming bad debts without first genuinely attempting to collect payment;
    - Paying owners or administrators amounts that have been determined to be excessive in prior cost report settlements;
    - Depreciating assets that have been fully depreciated or sold;
    - Utilizing depreciation methods not approved by Medicare;

- Listing interest expense for loans that have been repaid for an offset of interest income against the interest expense; and
- Improperly allocating costs to related organizations that have been determined to be improper.

9. Payments to Teaching Hospitals. Liability may arise when a hospital falsely indicates that a teaching physician supervised a service or attended a procedure. The rule provides that in order for the facility to bill for Medicare services provided by residents and interns, the clinical faculty member must be physically present with the resident either during the key portion or all critical portions of the medical services provided.

10. DRG Payment Window. This Medicare rule requires that Medicare payment include all of a hospital's "operating costs of inpatient hospital services" which have been defined as incorporating all operating costs and ancillary services operating costs, including all outpatient services provided to a patient by a children's hospital (or an entity wholly owned or operated by the hospital) during one (1) calendar day immediately preceding the patient's admission to the hospital.

    Problems with the DRG Payment Window rule arise when claims are submitted to Medicare for payment of outpatient services which occurred during the immediate one (1) calendar day period preceding the date of the patient's admission to a hospital when those services were related to the inpatient admission.

11. Billing for Services Inconsistent with the Requirements that Hospital Services Were Furnished Directly or "Under Arrangements". No payment is to be made under Medicare (under either Part A or Part B) for any services provided by a hospital that are not furnished to hospital patients directly or "under arrangements."

12. Duplicate Billing. Duplicate billing occurs when the hospital submits more than one claim for the same service or the bill is submitted to more than one primary payor at the same time. Although duplicate billing can occur due to simple error, systematic or repeated double billing may result in false claim liability, particularly if any overpayment is not promptly refunded.

13. Erroneously Billing for Transfer Patients. Virginia Medicaid regulations include special payment rules for patients discharged from one inpatient setting to another inpatient setting. Instead of paying the transferring hospital a full DRG payment amount, if a patient is transferred to another inpatient setting within five (5) days with the same or similar diagnosis, Virginia Medicaid pays the transferring hospital a per diem payment amount. Hospitals must report accurate discharge status codes on claims so that they are paid correctly.

14. Failure to Refund Credit Balances. Hospitals are required to make refunds of any credit balances on patient accounts.

15. Return of Identified Overpayments. In accordance with Section 6402 of the Patient Protection and Affordable Care Act (the Health Reform Bill), providers have only 60 days to report identified overpayments to the applicable public payer (Medicare, Medicaid, Tricare). A provider has identified an overpayment when the provider has determined that an overpayment exists and has quantified the amount of the overpayment. Providers must act with reasonable diligence to investigate potential overpayments. If the provider fails to use reasonable diligence to investigate potential overpayments and does not meet the 60 day repayment deadline, the failure to report and repay may constitute a violation of the civil False Claims Act and result in monetary penalties. CHS shall report and refund all identified overpayments to public payers in compliance with applicable law.

EXHIBIT B – Employee Notice for Compliance with Deficit Reduction Act of 2005
EMPLOYEE NOTICE - COMPLIANCE WITH FALSE CLAIMS LAWS

CHKDHS prohibits all forms of false claims activity. The federal False Claims Act, the Virginia Fraud Against Taxpayers Act and the North Carolina Medical Assistance Provider False Claims Act also prohibit this illegal conduct and protect employees who report false claims. CHKDHS expects and requires the cooperation and assistance of all its employees and contracted vendors to protect against false claims activity.

All employees are responsible for adhering to CHKDHS' *Corporate Policy #C5411, Corporate Compliance Program*. An employee who believes that false claims activity has occurred shall immediately report all relevant information about the conduct to his or her immediate supervisor. If the employee believes the supervisor is involved with or otherwise has knowledge of the suspected fraudulent activity, the employee must immediately report the information to the next level supervisor or the CHKDHS Compliance Officer or utilize the Corporate Compliance Hotline by calling **1-877-373-0128**.

To maintain the confidential nature of any report, employees should not discuss any suspicion or knowledge of a false claim with other employees other than his or her immediate supervisor or the person to whom the report was made (unless directed by a member of management or the Compliance Officer). Upon notification of false claims allegations, the informed supervisor shall immediately contact his or her supervisor or a member of management or the Compliance Officer.

CHKDHS will conduct a thorough investigation and will confer with the reporting employee as appropriate. If the investigation reveals that the employee's report of suspected false claims is valid, CHKDHS will take prompt responsive action to stop the activity/conduct and to prevent its recurrence. CHKDHS will advise the reporting employee of the outcome of its investigation as well as the actions taken to address the concerns. CHKDHS will also report any such activities to regulators, as appropriate.

The Federal False Claims Act
This law prohibits any false claim to the Government or to a government contractor, grantee or other recipient of government funding. Some examples of false claims are billing for medically unnecessary services, billing for unsubstantiated services, billing for services not provided, and failing to return credits for overpayments. This law imposes significant civil, criminal and administrative penalties against the violator. The government is required to investigate allegations of false claims and may file civil suits for such claims. A private individual (known as a "qui tam plaintiff" or "whistleblower") also has the right to file a suit in such instances. There are time limits for filing such suits. CHKDHS' policy and this law prohibit any retaliatory action such as discharge, demotion, or suspension against an employee because of his or her involvement in a false claim disclosure and investigation. If such action occurs, the employee is entitled to bring an action in court against the employer.

Virginia Fraud Against Taxpayers Act and North Carolina Medical Assistance Provider False Claims Act
Both these laws prohibit fraud in state programs, purchases, or contracts. These laws prohibit false claims made to the Commonwealth of Virginia and its agencies and to the North Carolina Medical Assistance Program. Examples of actions that violate these laws include submitting a false claim for payment to the state Medicaid program or making or using a false record to get a false claim paid. Like the federal False Claims Act, these state laws impose significant civil and criminal penalties against a person filing a false claim and prohibit retaliation against an employee because of his or her involvement in a false claim disclosure and investigation. The Virginia law, like the federal False Claims Act, permits a private individual as well as the government to file suit for such claims.

Summary
CHKDHS is dedicated to enforcing the requirements of these laws. As an employee, you have the right to address your problems or concerns to your supervisor, the Compliance Officer and/or to other officers of CHKDHS, without fear of retaliation. If you feel that you have been retaliated against as a result of a report of suspected Medicaid fraud, waste or abuse, you should immediately advise the Compliance Officer or call the Corporate Compliance Hotline at **1-877-373-0128** so that appropriate action promptly can be taken.

EXHIBIT C – Contracted Vendor Notice for Compliance with Deficit Reduction Act of 2005

CONTRACTED VENDOR POLICY

CHKDHS POLICY FOR PREVENTING FALSE CLAIMS ACTIVITY

Children's Hospital of The King's Daughters Health System ("CHKDHS") prohibits all forms of false claims activity. The federal False Claims Act, the Virginia Fraud Against Taxpayers Act and the North Carolina False Claims Act also prohibit this illegal conduct. CHKDHS expects and requires the cooperation and assistance of all its contracted vendors to ensure no false claims activity occurs.

CHKDHS requires that its contracted vendors also report to CHKDHS in accordance with the procedures described below any suspected false claims. A contracted vendor who believes that false claims activity has occurred should immediately report all relevant information about the conduct to his or her corporate contact within CHKDHS. If the vendor believes such CHKDHS contact person is involved with or otherwise has knowledge of the suspected fraudulent activity, the vendor should immediately report the information to the CHKDHS Corporate Compliance Officer by calling (757) 668-7776 and asking for the Corporate Compliance Officer.

CHKDHS will conduct a thorough investigation and will confer with the reporting vendor as appropriate. If the investigation reveals that the report of suspected false claims is valid, CHKDHS will take prompt responsive action to stop the activity/conduct and to prevent its recurrence. CHKDHS will also report any such activities to regulators, as appropriate.

The Federal False Claims Act

This law prohibits any false claim to the Government or to a government contractor, grantee or other recipient of government funding. Some examples of false claims are billing for medically unnecessary services, billing for unsubstantiated services, billing for services not provided and failing to return credits for overpayments. This law imposes significant civil, criminal and administrative penalties against the violator. The government is required to investigate allegations of false claims and may file civil suits for such claims. A private individual (known as a "qui tam plaintiff" or "whistleblower") also has the right to file a suit in such instances. There are time limits for filing such suits. CHKDHS' policy and this law prohibit any retaliatory action such as discharge, demotion, or suspension against an employee because of his or her involvement in a false claim disclosure or investigation. If such action occurs, the employee is entitled to bring an action in court against the employer.

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Both these laws prohibit fraud in state programs, purchases, or contracts. These laws prohibit false claims to the Commonwealth of Virginia and its agencies and the North Carolina Medical Assistance Program. Examples of actions that violate these laws include submitting a false claim for payment to the state Medicaid program or making or using a false record to get a false claim paid. Like the federal False Claims Act, these state laws impose significant civil and criminal penalties against a person filing a false claim and prohibit retaliation against an employee because of his or her involvement in a false claim disclosure and investigation. The Virginia law, like the federal False Claims Act, permits a private individual as well as the government to file suit for such claims.

Summary

CHKDHS is dedicated to enforcing the requirements of these laws. As a CHKDHS contracted vendor, you are expected to comply with all requirements of these laws and report to CHKDHS any suspected false claims activity in accordance with the procedures set forth above.