Banner Health

Title: **Compliance: Basic Requirement for Third Party Billing; Prohibited Billing Practices**	
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Discrete Operating Unit/Facility:

Banner Baywood Medical Center
Banner Behavioral Health
Banner Boswell Medical Center
Banner Casa Grande Medical Center
Banner Churchill Community Hospital
Banner Del E Webb Medical Center
Banner Desert Medical Center
Banner Estrella Medical Center
Banner Fort Collins Medical Center
Banner Gateway Medical Center
Banner Goldfield Medical Center
Banner Heart Hospital
Banner Ironwood Medical Center
Banner Lassen Medical Center
Banner Payson Medical Center
Banner Thunderbird Medical Center
Banner—University Medical Center Phoenix
Banner—University Medical Center South
Banner—University Medical Center Tucson
Community Hospital
East Morgan County Hospital
McKee Medical Center
North Colorado Medical Center
Ogallala Community Hospital
Page Hospital
Platte County Memorial Hospital
Sterling Regional MedCenter
Washakie Medical Center
Banner Corporate
Banner Health Clinics
Banner MD Anderson Cancer Center
Banner Health Network
Banner Home Care and Hospice
Banner Plan Administration
Banner Pharmacy Services
Banner Surgery Centers
Banner Urgent Care Centers
Occupational Health/Employee Services
Post-Acute Care Services
Research
Rural Health Clinics
University Physicians Health Plans

I. Purpose/Population:

A. This policy summarizes several rules and/or regulations that apply whenever Banner Health (Banner) bills a third-party insurer (including Medicare and other government payers) for health care services, professional services, and supplies provided to Banner.
B. This policy applies to All Employees.

II. Definitions:

A. N/A

III. Policy:

A. Banner will not knowingly bill a third-party payer (including Medicare and other government payers) for any health care product or service that does not **meet** each of the following requirements:

1. **Ordered by a Physician or Other Appropriately Licensed Practitioner.** Unless pursuant to the Ethics & Compliance Department's Position Statement entitled "Billing Medicare for inpatient services with incomplete or missing orders", a healthcare product or service must be ordered by a physician or by another appropriately licensed practitioner. Orders must be documented, and documentation of orders must be retained, in accordance with applicable facility, regional or state policies.
    a. **Standing Orders.** Products or services provided pursuant to standing orders may only be billed if the standing order is:
        i. specifically designed to address the patient's medical condition, and
        ii. is reviewed, signed or authenticated and dated by the ordering physician no less frequently than every twelve months. Documentation should reflect that a product or service is provided pursuant to a standing order and the standing order should be included in the patient's medical record.
    b. **Protocols.** Products or services provided to a patient pursuant to a written protocol that has been properly adopted by a facility's medical staff may be billed. The protocol should be specifically referenced in documentation by the nurse or other clinician who provides a product or service.
    c. **Verbal or Telephone Orders.** Products or services provided pursuant to verbal or telephone orders may be billed if the verbal or telephone order is documented, and signed or authenticated by the ordering physician, in accordance with any applicable facility, regional or system policies. In every case, verbal or telephone orders should be dated, timed, and authenticated promptly (within 48 hours if no State Law is applicable or according to State law) by the ordering practitioner or another practitioner who is responsible for the care of the patient and authorized by hospital policy to write orders.

    Note: Verbal orders can be taken only in an emergency situation.

2. **Medical Necessity.** Banner can only seek reimbursement from third-party payers for products or services provided to patients if the products or services are medically necessary or are otherwise covered by the payer (e.g., covered screening services). Determination of whether a service is medically necessary should be made by referring to the payer's general guidance about medical necessity, and specific guidance on when particular services are and are not medically necessary.
    a. **General Guidance.** In many situations the determination of medical necessity is made by the ordering physician. For these situations many payers have provided

general guidance. Medicare statutes, for instance, provide that care will only be covered by Medicare if it is "necessary for the treatment of an injury or illness."

b. **Specific Guidance.** In some situations a payer will provide specific guidance on when a product or service is medically necessary. For example, Medicare periodically publishes National Coverage Determinations, and Medicare fiscal intermediaries and carriers have been given authority to develop Local Coverage Determinations (LCDs), all of which provide specific guidance on matters such as diagnosis for which a service will be covered and frequency of visits that will be covered as medically necessary. Where such specific guidance has been provided, it must be followed when determining whether a service is medically necessary and may be billed.

3. **Documentation.** Services billed by Banner must be supported by documentation found in the patient's medical record. If a payer has developed specific documentation rules for a service or set of services (e.g., *Documentation Guidelines for Evaluation and Management Services* or documentation requirements of Medicare's Teaching Physician Rule) documentation in the patient's medical record must meet the requirements of the specific documentation rule to be billed. Documentation should reflect the specific product or service provided in a manner that, to the extent possible, removes any ambiguity in identifying appropriate charge codes. Documentation should be legible. Documentation supporting services billed should be entered into the patient's medical record before a claim is billed. Documentation entered into the medical record should be available to coders and should be the basis for selection of codes billed.

B. **Prohibited Billing Practices.** Banner employees and agents may not intentionally or knowingly violate any of the following proscriptions when submitting bills for health care products or services to third-party payers (including Medicare and other government health care programs) or to individual patients. Any violation of this policy that appears to be intentional must be immediately reported to Banner's Chief Compliance Officer. If unintentional violations are discovered, Banner will take all reasonable steps to cure any harm caused by the discovered violations.

1. **Billing for Items or Services That Have Not Been Rendered.** Banner employees and agents may not submit bills for items or services that have not actually been provided to a patient.

2. **Billing for Items or Services Based on Falsified Documentation.** Banner employees and agents may not create false documentation, and may not submit bills for items or services that are supported by documentation that has been falsified. Falsified documentation includes, without limitation:
   a. notes of visits or procedures that were not actually performed;
   b. documentation that intentionally misconstrues or exaggerates a patient's diagnosis or condition to obtain coverage at a higher level than is justified by the patient's actual condition;
   c. forged signatures on visit notes, procedure notes, or orders for products or services;
   d. false documentation of a clinician's presence or involvement in a visit or procedure when the clinician was not, in fact, present or involved.

3. **Billing for Services Using a Provider Number Not Assigned to the Providing Clinician.** Unless allowed by a specific rule, regulation or contract provision, Banner employees and agents may not submit bills for services using the provider number of a clinician who was not the actual provider of services.

(Exception Example: Medicare's incident-to-rule allows billing with the physician's Medicare provider number for certain professional services provided by the physician's employed ancillary staff. For example, a follow-up visit by the physician's employed nurse practitioner could, in certain situations be billed using the physician's provider number.)

4. **Billing for Items or Services Using Codes or Charge Code Information That Does Not Accurately Reflect the Items or Services Provided.** Banner employees and agents may not submit bills for items or services with codes or charge codes, modifiers, or other billing information that does not accurately reflect the items or services that were actually provided.

IV. Procedure/Interventions:

A. Clinical department managers and Clinic Compliance Officers review National Coverage Determinations, and/or Local Coverage Determinations and other payer policies that apply to the services they manage and should take appropriate steps to communicate those policies to affected staff members, and confirm that department activities are consistent with the policies. Documentation of the clinical manager's review, of communication or training for staff members, and of efforts to confirm compliance, should be maintained in the department manager's and Regional Clinic Compliance Officer files.

1. **Local Coverage Determinations** can be accessed on Medicare intermediary and carrier web sites. (Medicare Administrative Contractors (MAC))

2. **National Coverage Determinations** can be accessed at http://www.cms.hhs.gov/coverage/.

B. Clinical department managers and Regional Clinic Compliance Officers should review or have reviewed a sample of patient records from their areas of responsibility as per Banner's Compliance Policy, Monitoring for Compliance.

C. If a review conducted pursuant to this policy identifies a failure to meet a standard established by this policy, the identified failure must be reported to a Banner Compliance Officer. Reports to a Facility Compliance Officer, a Regional Clinic Compliance Officer, or to the Chief Compliance Officer will satisfy this requirement.

V. Procedural Documentation:

A. N/A

VI. Additional Information:

A. N/A

VII. References:

A. N/A

VIII. Other Related Policies/Procedures:

A. Compliance: Monitoring for Compliance

IX. Keywords and Keyword Phrases:

A. Compliance

B. Billing
C. Medical Necessity
D. Documentation
E. Orders

X. Appendix:

A. N/A