BERRIEN MENTAL HEALTH AUTHORITY
PROCEDURE

SUBJECT: Billing for Services	SECTION: 07-02-35 Page 1 of 5
APPLICATION: All Staff EFFECTIVE DATE: 11-28-01 REVISED: 11/04, 11/06, 07/08, 8/10, 11/11, 4/15, 10/15, 3/16, 6/17, 2/18, 4/19, 6/2021, 3/2022, 5/2022, 5/2024	REQUIRED BY: False Claims Act, Michigan False Claims Act, Stark Law I & II MDHHS, CARF, and CMS

POLICY: Berrien Mental Health Authority (BMHA) will adhere to all laws and regulations when billing for services provided. BMHA promotes a culture that prohibits any activity that would result in fraud, abuse or waste as defined by the Federal and Michigan False Claims Act.

PURPOSE: To ensure full compliance with billing requirements.

STANDARDS:

1. Employees and contractors who are involved in any aspect of BMHA billing for services will be held to the highest ethical standards with respect to knowledge and adherence to the requirements and standards for participation in the healthcare industry, including but not limited to, all rules and regulations pertaining to the submission of bills and reimbursement under Medicare, Medicaid and third-party payers.

2. Employees and contractors will receive training regarding the submission of bills and claims including specific information related to the Deficit Reduction Act of 2005, Federal False Claims Act, Michigan False Claims Act and other applicable laws.

~~3.~~ Clinical staff will be properly licensed and credentialed by the appropriate governing body. When a clinician begins employment, they are required to meet with the Reimbursement Office Manager. This is reflected in their orientation schedule. When they meet with the Reimbursement Office Manager, if the clinician does not have a National Provider Identifier (NPI), one is applied for during this meeting. Once the NPI number is issued, a copy of the confirmation email is given to the Reimbursement Office Manager and the clinician. It is then entered into the IRIS system under the clinician's account in the Credentials section. Copies of the clinician's license along with a printout from the Department of Licensing and Regulatory Affairs (LARA) are forwarded to the Reimbursement Office Manager. If the clinician is Medicare billable (MD, DO, LMSW, LPC etc.), the Reimbursement Office staff will apply for a Provider Transaction Access Number (PTAN), so their services can be billed.

4. Accurate billing and claims submission require cooperation and effective communication between billing staff and clinical staff. An effective billing program requires that all staff involved in the consumer care process be diligent with respect to proper and timely documentation.

5. Employees and contractors are responsible for seeking clarification when in doubt of a billing or coding procedure. In the event an answer cannot be obtained internally, contacting the Michigan Department of Health and Human Services (MDHHS) or other outside agencies must be coordinated with the Director of Regulatory Compliance, Director of Behavioral Health Services or Director of Provider Network. The inquiry and answer obtained must be properly documented and a copy sent to the Director of Regulatory Compliance, Director of Behavioral Health Services and Director of Provider Network.

6. To ensure all services are properly billed, all documentation must be completed in an accurate, organized, legal and timely manner. The Medicaid Provider Manual states providers must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries. The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed. All documentation for services provided must be signed and dated by the rendering healthcare professional. Employees and contractors will electronically sign the documentation when all documentation and billing requirements are satisfied. Billing staff will only submit claims when the clinical documentation supports the services being billed. The documentation should accurately reflect:
    - Consumer's legal name
    - Service provided
    - Date of service
    - Location of service (e.g. office, community, home, etc.)
    - Start and Stop time/Duration
    - Individual providing the service and credentials
    - The diagnosis must support the service provided and it must be medically necessary
    - Supervising professional when indicated
    - Current assessment and Individual Plan of Service goals and objectives
    - Treatment interventions/methodologies provided
    - Consumer progress toward Individual Plan of Service goals and objectives
    - Consumer response/satisfaction with services
    - Rendering provider signature and signature date

DEFINITIONS:

1. **Fraud** – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person. In other words, it is intentionally attempting to deceive or execute a scheme to falsely obtain money or other benefit from a healthcare program.
2. **Abuse** – Improper practices that are inconsistent with sound fiscal, business, or clinical practices and result in unnecessary cost or reimbursement for services that are not medically necessary or fail to meet professionally recognized standards of care.
3. **Waste** – Overutilization of services or other practices that result in unnecessary costs. Generally, not considered caused by criminally negligent actions but rather the misuse of resources. In other words, spending that can be eliminated without reducing quality of care.

4. **Payer** – The Entity responsible for paying for services that were provided.

Billing Rules

1. **Bill only for services rendered.** Claims will only be submitted to payers when there is documentation that supports face-to-face services being billed. All documentation requirements will be completed prior to electronically signing the document and marking the transaction ready to complete.

2. **Bill only for medically necessary services.** Claims will only be submitted for services that BMHA believes are medically necessary and were ordered by a physician or other appropriately licensed provider. 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 payer.

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. All claims will be checked for duplication of codes for multiple services.

6. **Ensure no duplicate billing occurs.** All claims will be checked to ensure no more than one claim is submitted for the same service. Claims are to be submitted in accordance with the most current versions of the Behavioral Health Code Sets, Charts, and Provider Qualifications and Michigan Medicaid Provider Manual.

7. **Do not routinely waive co-payments and deductibles.** Consumers must be billed for co-payments and deductibles unless the consumers have been determined to be indigent. The consumer will only be billed for the portion determined by the policy and procedure on "Ability to pay."

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

9. **Do not submit charges for services unless there is a current Individual Plan of Service and Assessment.** Charges for services cannot be submitted for billing unless there is a current Individual Plan of Service and assessment that covers the date(s) of service. This also requires BMHA bill only for services included in the Individual Plan of Service that support medical necessity.

Billing Discrepancies

1. **Reporting of claims with suspected discrepancies.** Any **c**laim suspected of having an error should be reported to the Director of Regulatory Compliance or the Anonymous Compliance Hotline (800) 876-2501.

2. **Discrepancies Review.** The Director of Regulatory Compliance will investigate the suspected discrepancy and if necessary, take corrective action including the development of steps to prevent its recurrence. Any disclosures of payments made to a funding source will be submitted by or in coordination with the Director of Regulatory Compliance.

3. **Refunding of overpayments.** Any overpayments received will be repaid within sixty-days (60) to the appropriate payer.

Disciplinary Action: All employees and contractors are expected to act in accordance with the billing rules set forth in this policy. Failure to do so may result in disciplinary action, recoupment of funds or termination of contract.

Deficit Reduction Act: Pursuant to certain provisions of the Deficit and Reduction Act of 2005, the following information has been included to provide employees and contractors with educational information regarding false claims. Employees and contractors are responsible for following BMHA's standards of conduct including using good faith efforts to comply with applicable laws and conducting business in an ethical manner.

Information Regarding False Claims: All employees and contractors should understand that the submission of false claims is prohibited by several different statutes. In general, a violation of the false claims laws includes submitting or causing to be submitted a false claim for payment to the federal or state government (or using a false record to get a claim approved) when the claim is false or fraudulent. The submission of a false claim may result in civil or even criminal penalties. The False Claims Act applies to cost reporting matters as well as fee for service claims. For cost reporting entities, claims for items or services for the purposes of the statute include entries or omissions in cost reports, books of account, or other documents supporting the claims.

The Federal Civil False Claims Act prohibits the knowing submission of false or fraudulent claims for payment to the federal or state government, the knowing use of a false record or statement to obtain payment on a false or fraudulent claim, or a conspiracy to defraud the federal or state government by having a false or fraudulent claim allowed or paid. Violations of the False Claims Act may result in substantial civil monetary penalties of up to $11,000 per false claim, three times the damages sustained by the government and exclusion from participation in Medicare and Medicaid programs.

Under the Federal Civil False Claims Act, to knowingly present a false claim means that a person (1) has actual knowledge that the information on the claim is false (2) acts in deliberate ignorance of the truth or falsity of the information on the claim; or (3) acts in reckless disregard of the truth or falsity of the information on the claim. The deliberate intent to defraud is not required to be found in violation of the Act.

The Federal Criminal False Claims Act prohibits knowingly and willingly making or causing to be made any false statement or representation or material fact in any claim or application for benefits under Medicare or Medicaid. Violations are felonies and are punishable by imprisonment and/or fines.

The Civil Monetary Penalties law prohibits submission of claims to Medicare or Medicaid that a provider knows or should know are false or fraudulent and provides for the imposition of sizable penalties.

The Health Insurance Portability and Accountability Act of 1996 amended the federal penal code to criminalize federal healthcare offenses. These offenses include, for example, healthcare fraud that covers fraud against any public or private healthcare benefit program or obtaining money by false pretenses in connection with the delivery or payment of healthcare benefits. The offenses also include false statements relating to matters concerning any public or private healthcare benefit program. These offenses are punishable by fine or imprisonment, or both.

Other federal criminal laws may be used to prosecute the submission of false claims, including prohibitions on making false statements to the government and engaging in mail fraud. Felony convictions will result in exclusion from Medicare and Medicaid and other federal programs for a minimum of five years.

The State of Michigan also has a law (known as the Michigan False Claims Act) prohibiting fraud in obtaining payments in connection with the Medicaid program. This law is similar to the Federal False Claims Act. It also protects employees who initiate, assist or participate in a proceeding or court action under this law or who cooperate or assist with investigations conducted under this law.

Non-Retaliation: Employees and contractors are responsible for reporting compliance issues including issues that raise false claims concerns. If an employee or contractor suspects fraudulent activity, it is their responsibility to report it to the Director of Regulatory Compliance or to the Anonymous Compliance Hotline (800) 876-2501. No employee who makes a report of alleged wrongdoing in good faith will be subjected to reprisal, harassment, retribution, discipline or discrimination by BMHA or any of its employees or agents based on having made the report. Any employee who engages in any such reprisal, harassment, retribution, discipline or discrimination against a good faith reporter may be subject to disciplinary action as deemed appropriate by BMHA. The Michigan Whistleblowers' Protection Act also provides protection to employees who report a violation or suspected violation of state, local or federal law. The Federal False Claims Act also contains protections for employees, who are discharged, demoted, suspended or discriminated against in retaliation for their involvement in false claims act cases.

Source: Section 6032 of the Deficit Reduction Act of 2005
42 USC Section 1396a (a)68)

REVIEWER: Director of Regulatory Compliance
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