
	Policy No.: 314	Signature: 	
	Created: 2/2004	Reviewed: 5/2018	Revised: 1/2007

GENERAL CODING AND BILLING FOR HOSPITALIST SERVICES

SCOPE:

All Envision Physician Services and its subsidiaries’ (the “Company”) colleagues involved in billing and coding for hospitalist services. For purposes of this policy, all references to “colleague” or “colleagues” include temporary, part-time and full-time employees, independent contractors, clinicians, officers and directors.

PURPOSE:

The purpose of this policy is to outline the general billing and coding policies to be followed by the Company’s Hospitalist and billing entities.



POLICY:

This Policy contains the general policies and procedures that direct the billing and coding entity’s efforts towards compliance. Additionally, integral and detailed components of this policy are the Billing Entity Training Manuals, Billing Entity Billing and Coding Procedure Manuals and Hospitalist Handbook. These documents are not contained within this booklet but are referenced throughout it. The training and procedure manuals are separately maintained by the respective billing entities in conjunction with the Compliance Officer and the Hospitalist Handbook is presented during new hire orientation and available to all Hospitalist via the Company website. All individuals responsible for revising and implementing the policies and procedures contained in other manuals must ensure that these revisions appropriately reflect in this policy. If any inconsistencies exist between other manuals and this policy, then the Policy in this Program governs.

It is expected that all colleagues and independent contractors associated in any way with the billing and coding process adhere to the standards of billing and coding outlined in this policy.

The Company and their colleagues will comply with all laws pertaining to the billing of Medicaid, Medicare, and other federal claims, as well as the guidelines and requirements of private payors.

To enhance communication and understanding of the standards of billing, each billing entity Compliance Officer and Hospitalist RCOO and RCEO will serve as liaison to the Company’s Chief Compliance Officer. The liaisons will serve as focal points for compliance-related communications and work closely with their staff to achieve regulatory compliance. Questions

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regarding billable services should be directed to the colleague’s supervisor or Compliance Officer for clarification prior to entering a charge and submitting a claim.

It is the Company’s policy that all bills for physician services are appropriately coded to support the level of documentation in the medical record and that the claim be submitted in the name of the correct provider. The “coder” as defined in this policy is either the treating physician or the billing entity’s professional coder. The coder is responsible for assigning or abstracting the appropriate codes for each treatment or service furnished. For claims submitted to government payors, the coder is required to select the appropriate codes based on the 1995 *Centers for Medicare & Medicaid Services (CMS, formerly known as Healthcare Financing Administration) Evaluation and Management Codes Documentation Guidelines*. For other third party payors, the coder is required to select the appropriate codes based on the CPT code book.



For procedural coding, the CPT code selected must meet or exceed the current CPT-coding manual book narrative. Coders will reference code narratives in the CPT book if there is a question or will contact the departmental representative responsible for coding information, and/or consult the Compliance Officer for clarification and/or assistance prior to submitting the charge sheet to the billing entity.

A current ICD code is required for each professional service rendered by a provider to a patient to reflect medical necessity of the service/procedure. The physician is required to document a description of the patient’s diagnosis, in order for the billing entity’s coding staff to identify the appropriate ICD code for billing purposes. The billing entity’s coders are accountable for selecting the appropriate diagnosis and should sequence the diagnosis, condition, problem, complaint or other reason responsible for the encounter. If unsure of the appropriate ICD code, questions should be directed to their manager or the Compliance Officer.

It is the policy of the Company that coders use the proper ICD; CPT or HCPCS codes for services documented in the medical record and reflect the appropriate provider of services. To insure compliance with these policies, the Company will conduct an initial audit within the first 60-90 days of any new contract. In addition, quarterly audits will be conducted allowing every client to be audited annually.

All departments and individuals shall comply with the Company's billing and coding policies, and interpretations different from or actions inconsistent with this policy are prohibited. Due to the dynamic changes, intricacies and possible misinterpretations of billing standards, all professional service billing personnel must actively participate in the Professional Billing Compliance Program to ensure consistency with policies or legal requirements regarding billing.

The supervisors shall recommend and implement discipline for any individuals who do not exercise the quality standards required. The supervisors will follow the Disciplinary Action Policy included in this Program. Written procedural documents on the standards of billing can be found in the respective billing entities Training Manual and Coding Procedures Manual.

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Also, there are several billing and coding policies included in the Compliance Program relating to high-risk areas for the industry in which the Company does business.

POLICY REVIEW

The Ethics & Compliance Department will review and update this Policy and all HIPAA policies when necessary in the normal course of its review of the Corporate Ethics & Compliance Program.