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<b>REVIEWED BY:</b> CPG Policy Workgroup; QRSCC			<b>APPROVED BY:</b> QRSCC	

## Purpose

The purpose of this policy is to provide guidance for conducting routine monitoring of healthcare claims by the CHRISTUS Physician Group (CPG) Compliance Department.

## Policy

CPG Compliance Department shall conduct routine monitoring as outlined in the Compliance Work Plan.

## Definitions

**Codes** mean the relevant issue of Current Procedural Terminology (CPT), Health Care Procedural Code Services (HPCS), Internal Classification of Diseases, Version 9 (ICD-9-CM) and Internal Classification of Diseases, Version 10 (ICD-10-CM).

**Compliance Work Plan** means the fiscal year work plan, as modified from time to time, which identifies areas to monitor to identify, minimize and reduce compliance risks.

**Claims** mean the CMS 1500 and/or ANSI file containing the billing information, including patient demographic information and codes, which is submitted to the payer for payment purposes.

**Billed Encounter** means all healthcare items/services billed by a provider for a patient on a single date of service regardless of the number of claims submitted.

**Provider** means anyone who bills for healthcare items/services under his/her own name, including, but not limited to Physician (MD or DO), Advance Practice Registered Nurse (APRN), Physician Assistant (PA), Audiologist, Pharmacist (PharmD), Physical Therapist, or Occupational Therapist.

## References

[Office of Inspector General \(OIG\) Compliance Guidance for Small Physician Practices.](#)  
[Office of Inspector General Compliance Guidance for 3<sup>rd</sup> Party Billing Companies](#)

## Procedures

<b>REVIEW PERIOD:</b>	<b>REVIEW DATES:</b>					
<input checked="" type="checkbox"/> Annual	10/23/2014					
<input type="checkbox"/> Bi-Annual						
<input type="checkbox"/> Other:						

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## **A. General Responsibilities**

### **1. CPG Compliance Specialist Responsibilities**

- a. Each CPG Compliance Specialist (“Monitor”) shall be assigned areas of responsibility for monitoring activity in accordance with the Compliance Work Plan. It is the responsibility of each Compliance Specialist to timely conduct, and complete their assigned monitoring duties.
- b. Monitors are responsible for identifying all billing Providers in their assigned Regions to include, practice location(s); specialty; use of mid-level providers; date of hire/contract; start date; orientation date; and any other relevant information to assist in accurately monitoring billing activity..
- c. Monitors shall timely and accurately track and report on monitoring activity as directed under the Work Plan and Compliance Director.
- d. The Monitors shall be responsible for maintaining and updating the [CPG Monitoring Handbook](#), ensuring that it accurately reflects current Medicare/Medicaid payment policies. A revised Handbook shall be drafted no later than the end of January each calendar year to incorporate changes during the last calendar year.

### **2. Regional Clinic Responsibilities**

- a. Each Clinic Practice Manager, Administrator and/or Director shall designate one or more persons as the point of contact for the Monitors.
- b. Designated Point of Contact
  - 1) The clinic/practice area point of contact shall assist the Monitors in timely:
    - a) locating missing or misfiled records;
    - b) locating hospital medical records not found in athenaNet, MediTech, HPF or any other electronic medical record system;
    - c) obtaining copies of paper medical records or other information required to complete the monitoring activity.

## **B. Monitoring Selection**

1. Monitoring selections shall be consistent with the Work Plan requirements. Additional monitoring/auditing may be initiated based on findings from the initial monitoring or if concerns are identified during the course of the routine monitoring.
2. Monitoring selections shall be made from billed encounters billed to Medicare/Medicaid wherever possible and then from other payers if there are not enough billed encounters from Medicare/Medicaid, subject to any restrictions in the Work Plan. Selections may be made retrospectively (after services are billed) or prospectively (before services are billed).

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3. Monitoring selections shall be focused on the Work Plan and where appropriate, the provider's unique billing/coding compliance risks, including factors such as previous monitoring results, internal or external audits, and/or government identified risk areas as provided by the Compliance Director. Selections shall be based on the type of services provided and should include, as appropriate, services involving inpatient and outpatient billed encounters, billed encounters with modifiers, consultations, teaching physician billed encounters, and procedures.

### **C. Monitoring Process**

1. New Providers shall be monitored within 60 days of the date they begin to see patients, regardless of whether or not they are credentialed with the payers.
2. The Monitors shall notify the clinic Practice Manager, Administrator, and/or Region Director prior to initiating the monitoring for that clinic/area in order to identify the points of contact for access to medical records and/or additional information necessary to conduct the routine monitoring.
3. The Monitors shall utilize the most current CPG Monitoring Handbook and current payer policies to conduct the monitoring, to include use of the appropriate CPG Monitoring tools. Monitoring will focus on the risk areas identified in the Work Plan, and where appropriate, the following:
  - a. Accurate date of service, billing provider, place of service indicator;
  - b. Accuracy of CPT/HCPCs codes billed for each billed encounter based on documentation in the medical record, including appropriate use of modifiers;
  - c. Accuracy of ICD-9 and ICD-10 codes as supported by documentation in the medical record;
  - d. Any other area as identified in monitoring tools and/or the CPG Compliance Director.
4. Preliminary Results.
  - a. Monitors shall timely provide preliminary monitoring results to the Point of Contact(s) for each provider in a clinic/practice.
  - b. Practices shall have ten (10) business days from the date of receipt from the Monitors to review those results with the Provider and respond. Any objections to preliminary findings must include a basis for the objection, to include, where applicable, any additional documentation that would impact the preliminary finding. If the practice fails to respond within the time provided (including any reasonable extensions), the preliminary findings will be final.

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5. Final Results.

- a. Monitors shall modify their preliminary findings based on any substantiated objections and finalize their results. The final results shall include appropriate corrective action, which may include, but is not limited to:
  - Refund of any identified overpayment and rebill of the service where appropriate;
  - Revision of templates, fee tickets or processes to eliminate errors;
  - Mandatory Education;
  - Notification of the Regional Physician Leader (RPL) and/or CPG Leadership of findings;
  - Suspension of billing pending further corrective action; and/or
  - Follow-up monitoring.
- b. Final results Report shall be timely given to practices and to the designated Revenue Cycle Management staff person (RCM Designee) for any services that require correction and/or refund.
- c. Final results shall be reported in accordance with the Work Plan and instructions from the Compliance Director. Such information shall include the amount that would have been paid for over-coded/down-coded services and that amount that should have been paid.

**C. RCM Designee Responsibilities**

1. The RCM Designee shall timely process any refunds and/or correction of claims.
2. With respect to any services that were “overcoded”, the RCM Designee shall ensure that:
  - a. All over-payments are refunded to the third-party payer within sixty (60) days from the date of the Final Results report.
  - b. Any refunds due to a patient are made within thirty (30) days from the date of the Final Results report.