MEDICAL PRACTICE MANAGEMENT SERVICES, LLC

POLICY, COMPLIANCE AND PRIVACY

Compliance.doc
Revision 1
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Revision Log

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Introduction:

This manual is created to voluntarily comply with the Office of Inspector General, Department of Health and Human Services continuing efforts to implement compliance programs in the healthcare industry. This manual is developed to ensure that proper measures are taken to protect personal and professional information of both patients and providers, to ensure that all billing submitted on behalf of clients complies with established legal guidelines, and that all provider clients are aware of Medical Practice Management Service's (MPMS'S) stance on preventing fraud, waste and abuse.

Standard of Conduct:

All MPMS employees and contractors are expected to adhere to all Federal and State Laws regarding proper billing procedures to ensure that there is no instance of waste, fraud or abuse. While it is in not the job of MPMS to audit providers, when a situation raises questions regard the compliance of the provider client, the MPMS representative should immediately contact their supervisor for direction on how to handle the situation.

At no time is any member of the MPMS staff to accept any gift from any provider client without prior approval of management. Token holiday gifts are acceptable. However, any other renumeration or compensation beyond the fees charged by MPMS could constitute violations of the anti-kickback statutes.

At no time is any employee or contractor to change billing related documentation provided by a client provider without the express consent in any way that would affect the payment of the claim. Any and all codes must be provided by the client provider.

Revisions:

Revisions to this manual will be made to the entire document, not by section. When a new revision is introduced, all employees and contractors will receive training on the revisions. Any revisions will supersede the original document. A revision control form will be maintained by the MPMS president.

Compliance Officer:

Vincent Romanelli serves as the MPMS compliance officer. Any concerns regarding internal or external compliance issues should be addressed to him at 412-577-8353. All calls to the Compliance Officer are confidential.

If at any time any member of the MPMS organization feels that there is a threat or compromise to the compliance of regulatory issues from the policies or practices of MPMS, the employee

should immediately notify their supervisor. If appropriate action is not taken, the employee and/or supervisor should immediately notify the compliance officer.

The Compliance Officer should address any communicated concerns directly to the MPMS President. The President will seek advice from the compliance officer on how to handle compliance related issues, and the President is responsible to ensure that corrective action is taken and reported back to the compliance officer. Any corrective action as a result of an identified compliance issue will be addressed as a training session with all staff members and properly updated into the compliance documentation.

The Compliance Officer is also responsible to ensure that all employees and contractors attend designated compliance training and that the training is electronically documented. All employees must be trained on all policy revisions. Training will include individual reading of the materials, group training session to review the entire manual and/or revisions, along with question and answer session as necessary. Additional training will take place as discrepancies in performance arise. All training will include competency testing, and the test results will be housed in the employees electronic file.

Anti-Kickback

The anti-kickback statute is a US law prohibiting a business or person from offering money to medical personnel in return for the recommendation of products or services to patients on certain federally covered medical programs, including Medicare/Medicaid.

MPMS expands this definition to include the provision of inducements by any provider client to a patient for the referral of another patient to that or any other provider for the provision of medical services. Such services may or may not be considered to be medically necessary under the law, and therefore providing an incentive for a referral could constitute Medicare/Medicaid Fraud.

MPMS prohibits the compensation to any source for the referral of a client provider to the services of MPMS. MPMS staff and employees are specifically prohibited from accepting any gifts, including meals, from any client provider. If a meal is shared with a member of the MPMS staff and a client provider, the meal is to be paid by MPMS staff, and a receipt submitted for reimbursement if applicable.

Approval:

This policy manual as a whole is approved and accepted by the management and ownership of MPMS. This policy manual will continue to grow and be enhanced to provide clear information on the expectations regarding adherence to laws, internal policies and the protection of patient and provider confidential information. Employees and contractors are expected to comply with the document version in force at the time. Questions should be immediately addressed to the employee or contractors direct supervisor. Any changes to this manual will be required a complete redistribution of the entire manual, and any new copies will supersede existing versions.

Melissa R Romanelli
President, Phoenix Rising Group, Inc.
Medical Practice Management Services, LLC

Distribution:

I, _____ confirm that I have received an electronic copy of the MPMS Compliance Manual and that I have completed compliance training. This document is to be stored on the employees Microsoft 365 One Drive. All testing regarding compliance matters will be stored electronically as well. While manuals may be printed, the official versions will be stored electronically with appropriate revision and date information. As an employee, I am responsible to ensure that I have the latest version as each revision is released.

Signed: _____

Date: _____

1.0 Provider File Management

1.1 Maintenance of Provider Information

All provider information will be maintained on a secured cloud system controlled by the MPMS President. At no time should information be loaded onto portable electronic media and removed from the cloud-based system. At no time should information be stored on personal (not owned by MPMS) computer equipment.

1.2 Storage of Provider Information

All provider information will be stored on a secured cloud system. A directory entitled "Credentialing" will house all documents. In each practice group will be created a subfolder in this directory. Each provider in the group will then have an individual subfolder beneath the practice folder.

All file names are to be in all lowercase letters. Abbreviations should be avoided when possible. Duplicate files are not to be maintained. Documents saved from insurance companies should be renamed to provide meaningful file name. All files are to use the following naming protocol to ensure retrievability and identification of provider documents:

[*provider name*] [*document name*] [*expiration date* (if applicable)]

Example: smith license 20180206

Under no circumstances are expired copies of documents to be maintained. Under no circumstances are files related to specific services provided to any patient to be maintained in the provider credentialing files.

1.3 Confidentiality of Provider Files

All credentialing related documents are to be maintained in a confidential manner. No member of the MPMS organizations should discuss the identity of MPMS provider clients with anyone outside of the MPMS staff.

All billing credentialing is to be shredded after processing. Shredding is to be placed in the secured and locked cabinet provided by the shredding contractor. Electronic copies of billing documentation are to be maintained on password protected computer systems. This requirement applies to but is not limited to the provider list used for billing and aging purposes.

All employees are expected to use only HIPAA compliance IOS secured cell phones for communication including text and phone messages. All devices must be password or scan protected.

1.4 Provider Signatures

All documents requiring original signatures by providers must be individually signed and dated by the provider. Under no circumstances should a signature be "cut and paste" onto any documents. If allowed by the insurance company, electronic signatures may be obtained using appropriate software applications.

Signature pages may be maintained as part of a digitally stored copy of an application. Separate signature pages are not permitted.

Signature pages are to be used for the application intended by the provider and signed documents should not be stored for future use.

1.5 Electronic File Maintenance

All electronic billing database files are managed by Microwize and stored on their cloud server. Microwize performs daily anti-virus scan and daily back up of all server files. Server files are backed up and encrypted daily, with back-up files being stored on a separate device. Microwize Business Associates Addendum documents and ensures all privacy measures are in place.

All files related to explanation of payment and benefits are stored on the Microwize server for the current year and backed up daily by Microwize. Historic files are stored on the File Cloud, managed by Microwize and maintained in the same fashion as main server files.

1.6 Patient Related Data

Under no circumstances is information related to patient information, services or claims to be stored within the Provider Files. All patient related information is to be maintained only in appropriate patient files.

2.0 Insurance Interface

2.1 Insurance Company Privacy Policies

All insurance company privacy policies will be strictly followed. This includes but is not limited to signature originality on credentialing and contract documents, establishment of online interfaces with insurance information, establishment of connectivity for claim submission or investigation and the handling of insurance payments. Any employee circumventing insurance company privacy policies will be subject to disciplinary action, including termination.

3.0 Database Setup and Maintenance

3.1 Fee Schedules

Each provider must provide and approve their own individual fee schedule. While MPMS may suggest fees based upon current Medicare allowance in the market, at no time is MPMS to set the fee for the provider.

3.2 Database security and integrity

All database files are managed by Microwize Technology, Inc. Microwize maintains log-in credentials for the database cloud server and the virtual network. Microwize provides daily data backup for each client database. Microwize provides general software technical support for both Lytec and Reimbursement Manager should with any technical issues arise.

All employees are set up on each individual database for access and fluidity in serving our customers. Each database is to maintain the same log in credentials. If at any time an employee experiences issues with logging into a database please contact your supervisor, not Microwize.

Lytec is not intended to encourage the billing of any codes as default codes or code combinations. All services are to be individually entered for billing purposes.

4.0 Billing and Claim Management

4.1 Billing for items or services not actually documented:

It is the responsibility of the provider to complete all documentation on patient services within 48 hours of the administration of that service. Services documented after that point are not billable per OIG Mandate. No member of MPMS will knowingly bill for services prior to the completion of required documentation or where the documentation is not completed within the required 48-hour window.

Should a client provider provide billing where the biller knows the documentation was not completed according to federal standard, the MPMS employee should immediately notify their supervisor. Any employee who knowingly submits billing for services not properly documented will be subject to disciplinary action, up to and including termination.

4.2 Unbundling

CMS provides definitions of what services are included within a code. Unbundling global services to obtain payment for services not payable under the bundling structure is considered to be fraud and abuse. Please note that there are instances when patient conditions and codes can be unbundled for the purpose of billing for treatment outside of the bundle.

Any employee who receives billing from a provider that they believe is for the purpose of unbundling to increase payment must be immediately communicate this to the supervisor. Under no circumstance is any employee or contractor of MPMS to unbundle or modify codes for the purpose of unbundling to increase payment. Any employee who knowingly unbundles global codes will be subject to disciplinary action, up to and including termination.

4.3 Upcoding

Upcoding occurs when a provider bills for a higher level of service than what was provided to the patient in order to obtain a greater reimbursement. Upcoding could include increasing a level of E & M code, or billing for additional time.

Any employee who receives billing from a provider that they believe is for the purpose of upcoding to increase payment must be immediately communicated to the supervisor. Any employee who knowingly upcodes any services will be subject to disciplinary action, up to and including termination.

4.4 Modifiers

Modifiers change the meaning of a CPT code. In some cases, the modifier will allow for services to be unbundled, or indicate if proper treatment plans are in place, along with other clinical aspects of a patients care. All modifiers must be provided by the billing client provider in order for them to be included in the billing claim.

One exception to this rule involves contractually assigned modifiers, particularly with managed care organizations. If a managed care organization (MCO) has assigned a specific modifier to be used for services in all cases, the biller may include that modifier without documentation from the client provider.

Any employee who includes modifiers with billing that is not contractually required or provided by the client provider will be subject to disciplinary action, up to and including termination.

4.5 Changes to submitted billing

Any time there is a question regarding the billing documentation submitted by a client provider, the biller must contact that provider via email to obtain clarification. If the provider responds with a change to the originally submitted billing documents, the biller is to store that change in their files for reference purposes. Alternatively, the biller may ask the provider to submit corrected billing document. Either way, confirmation of the appropriate changes must be electronically stored in the providers file. At no time is any MPMS employee to assume the changes that must be made in order to submit the billing. Any billing associated with that patient on that date of service should be held in the clients file until clarification is obtained.

Any employee who does not properly document changes to submitted billing will be subject to disciplinary action, up to and including termination.

4.6 Billing for services provided to another patient

Healthcare insurance policies specifically identify the individuals covered by said policy. At no time is any provider to render services to one person and bill those services under the name of another individual. Providers are responsible to verify that the person presenting themselves for services is also the person listed on the medical chart and the billing records.

Some providers service the patient through family or group services. The person listed on the billing records and the medical chart cannot be a bystander of the services and must be an active participant.

Billing for services under one name when the service is actually rendered to another person constitutes fraud. Any employee who believes this situation is occurring with any provider is to notify their supervisor immediately.

Any employee knowingly billing for services under the wrong patient name will be subject to disciplinary action, up to and including termination.

4.7 Audits

MPMS will conduct routine audits of all billing documentation and the corresponding electronic billing records. Audits will be conducted no less than once per quarter per provider client, and more often if remedial action is determined to be necessary. All new billers will have all clients audited monthly during the first six (6) months of employment or until such time as audit results are satisfactory.

Any discrepancies found in conjunction with an audit must be immediately corrected by the employee and communicated to the insurance company and the client provider.

4.8 Coding

MPMS does not provide coding services to clients. The coding submitted for billing is the express responsibility of the client provider. MPMS may advise providers on the definition and uses of a code, but the final code determination is left to the provider who rendered services to the patient.

4.9 Patient Confidentiality

All billing related documents are to be maintained in a confidential manner. At no time is any member of the MPMS staff to discuss or disclose information related to patients of any provider client. Additionally, no member of the MPMS organizations should discuss the identity of MPMS provider clients with anyone outside of the MPMS staff.

All billing documentation is to be shredded after processing. Shredding is to be placed in the secured and locked cabinet provided by the shredding contractor. Electronic copies of billing documentation are to be maintained on password protected computer systems.

All employees are expected to use only HIPAA compliance IOS secured cell phones for communication including text and phone messages. All devices must be password or scan protected.

4.10 Discharges from Care

At no time is any member of the MPMS staff to submit billing for a patient who is transferred to another service in lieu of being discharged.

4.11 Record Retention

All billing related records including day sheets, patient information and associated emails are to be maintained for a period no less than seven (7) years. All payment explanations from the insurance company are also to be maintained for seven (7) years. MPMS is responsible for maintaining electronic copies of electronic benefit explanations and will provide electronic records to the provider on a regular basis. The provider client is also responsible for not only maintaining electronic copies, but also any paper copies of payment information.

4.12 Insurance Credit Balance

MPMS will routinely review account balances and identify any credit balances. If a credit balance is determined to be the result of an overpayment from the insurance company, immediate action must be taken to notify the insurance company and the client provider of the credit. It is the responsibility of the individual employee to initiate actions to have the overpayment reimbursement process initiated with both the provider and the insurance company.

4.13 Electronic Posting Codes

Electronic posting codes are established in Revenue Management and maintained by the President of MPMS. Under no circumstances is any member of the MPMS staff to make any changes to the assigned posting codes without documented permission to do so.

4.14 Balance Billing

MPMS will provide services related to billing a patient portion of any services due from the patient, or balance billing. Balance billing is done after the insurance company has fully adjudicated the claim, and MPMS does not recommend sending any statement until the services have been fully processed by the insurance company.

Balance billing or patient responsible billing is based upon the patient's contract with their insurance company was well as the provider's contract with that insurance company. Additionally, fee assignment can play a role in the amounts a patient can be balance billed for out of network claims.

At no time is MPMS to bill a patient any amount greater than what the insurance company has indicated on the payment explanation documentation provided from the insurance company. Any employee who knowingly balance bills a patient for any amount greater than what is identified by the payment explanation will be subject to disciplinary action, up to and including termination.

4.15 Out of Pocket Billing to Medicaid Patients

Any patient who is Medicaid Eligible is not to have any out of pocket financial obligation other than one that may be identified on their explanation of payment. Patients who are Medicaid eligible may not be billed for missed appointments or non-covered services.

At no time is MPMS to bill a Medicaid patient for any amount greater than what the insurance company has indicated on the payment explanation documentation provided from the insurance company. Any employee who encounters such a situation should contact their supervisor for help in addressing this matter with the provider. Should the provider's actions continue, it is the responsibility of MPMS to notify the proper authorities and cease all business relationships with the client provider. Any employee who knowingly submits a bill to a Medicaid patient for any amount greater than what is identified by the payment explanation will be subject to disciplinary action, up to and including termination.

4.16 Advanced Beneficiary Notice (ABN)

Medicare requires that all services that may not be covered by Medicare be identified and communicated to the patient prior to the administration of services. The provider must indicate to the patient why the services may not be covered by Medicare and an estimated cost of the services. The patient must sign and Advanced Beneficiary Notice (ABN) to indicate that they

have been advised that the services may not be covered. If this documentation is not in place, and Medicare does not cover the service, the patient cannot be held financially responsible.

At no time is MPMS to bill a Medicare patient for any denied service without documentation that the ABN was properly signed prior to the administration of services. Any employee who encounters such a situation should contact their supervisor for help in addressing this matter with the provider. Should the provider's action continue, it is the responsibility of MPMS to notify the proper authorities and cease all business relationships with the client provider. Any employee who knowingly submits a bill to a Medicare patient for non-covered services without a signed ABN will be subject to disciplinary action, including termination.

4.17 Routine Waiver of Patient Responsibility

Patient responsibility is a contractual obligation between the patient and their insurance company and includes deductible, co-payment, co-insurance, and the financial obligations of non-covered services. Routine waiver of patient responsibility is considered to be fraudulent by the federal government.

Not all client providers request that MPMS provide tracking of patient responsible amounts and chose to maintain that function internally. This is their right.

MPMS does have the responsibility to address client providers who openly comment on the waiver or reduction of patient's financial responsibility. Any employee who encounters such a situation should contact their supervisor for help in addressing this matter with the provider. Should the provider's actions continue, it is the responsibility of MPMS to notify the proper authorities and cease all business relationships with the client provider. Any employee who knowingly reduces patient responsibility will be subject to disciplinary action, up to and including termination.

4.18 Patient Credit Balance

MPMS will routinely review account balances and identify any patient credit balances. If a credit balance is determined to be the result of an overpayment from the patient, immediate action must be taken to notify the client provider of the credit. It is the responsibility of the individual employee to initiate actions to have the overpayment reimbursement process initiated with both the provider and the insurance company. The patient is to be given the option to have a refund or to have the overpayment applied to future care.

Compliance Officer Roles and Responsibilities:

- Oversee and monitor the implementation of the compliance program;
- Reporting on a regular basis the progress of implementation and training;
- Conduct Risk Assessments and initiate changes to the compliance program based upon areas of exposure;
- Coordinate educational training of all compliance policies;
- Investigate and resolve reported compliance issues;
- Ensure that all employees are up to date with compliance training