| Samaritan Health<br>*830 Washington Street*<br>*Watertown, NY 13601* | **Billing and Claims Submission; Medical Necessity** | | **Document No.**<br>3503 |
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| **Business Units:** | Medical Center, Samaritan Home Health, Samaritan Keep Home, Samaritan Summit Village Assisted Living, Samaritan Summit Village Skilled Nursing, Centers and Clinics | | |

This Corporate Compliance Billing and Claims Submission Policy is applicable to Samaritan Medical Center and its Affiliates: Samaritan Keep Home, Samaritan Medical Practice, Samaritan Summit Village, and Samaritan Home Heath (collectively, "Samaritan").

**PURPOSE:**

To ensure that claims submitted for payment are in accordance with current billing, coding and claim reimbursement rules, policies and procedures identified by local, federal and state governments and third party payor requirements.

**SUMMARY:**

Samaritan routinely submits claims for the services provided and seeks reimbursement from both governmental and third-party payors. This policy provides guidance to all persons affected by Samaritan's risk areas, including employees, the chief executive officer of SMC and other senior administrators, managers, and contractors, agents, subcontractors, independent contractors, and governing body and corporate officers of Samaritan ("Affected Individuals"), as appropriate, to ensure that reimbursements submitted for payment for any service(s) that have been provided to patients or residents have been: provided as documented; properly documented; are medically necessary; and were provided by qualified persons.

**POLICY:**

Samaritan is committed to maintaining the accuracy of every claim it processes and submits. It is the policy of Samaritan to comply with applicable federal, state and local rules and regulations regarding documentation, coding and submission of claims for payment to all payors, including but not limited to Medicare, Medicaid and other federal health care programs.

**PROCEDURE:**

To ensure compliance with all the regulatory requirements and applicable billing rules identified by local, state and federal governments, as well as other third-party payors:

- Samaritan will only bill for the actual services rendered, and only when those services were consistent with accepted standards of care.
- All professional services rendered to patients/residents shall be documented in a proper and timely manner so that only accurate and properly documented services are billed.
- Claims will be submitted only when appropriate documentation supports the claims.
- All records of medical documentation used as the basis for claims submission shall be organized in a legible form to enable audit and review and retained in accordance with policy.
- The medical record and other clinical documentation shall support the diagnosis and procedures reported on the reimbursement claim, and the documentation necessary for accurate code assignment shall be available to the coding staff. If the documentation in the medical record is unclear, clarification or additional information from the physician or provider of services will be requested. Billing personnel cannot create coding or diagnostic information based upon their own interaction with the patient, from information provided from an earlier date of service, or based on what they may conclude is the probable or most likely diagnoses; any changes to the medical record must be accomplished in accordance with applicable Samaritan policies and procedures.
- Compensation for billing department personnel (including coders) and billing consultants shall not contain any financial incentive to submit improper claims or codes.
- Official coding guidelines promulgated by the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, the American Medical Association, the American Health Information Management Association and the state Medicaid program, along with any guidance or interpretation received from Medicare carriers or intermediaries, will be maintained and be available to billing and coding personnel for reference as needed.
- Previously submitted claims shall be randomly audited for accuracy and compliance with applicable rules and regulations and, when requested, the Chief Compliance Officer shall inform the appropriate third-party payor of any steps taken to monitor Samaritan's claim submission process.
- Claim denials shall be reviewed and appealed when appropriate. Valid claim denials shall be utilized to identify process and system improvements, when applicable.
- The appropriate third-party payor shall be promptly reimbursed for any overpayment received as a result of an identified billing and (where possible) the beneficiary shall be reimbursed for any co-payment or deductible incorrectly paid.
- Claims shall be submitted to state and federal health care programs (or private insurers) only for services that are believed to be medically necessary and that meet the requirements for each service or test provided or ordered by the responsible physician or other individual licensed to do so. Documentation supporting the same, such as forms containing diagnoses codes, shall be retained and submitted to said programs or payors on request.
    - Practitioners who provide or supervise the provision of services to a patient will be responsible for the correct documentation of services that were rendered.
    - Practitioners are responsible for assuring that for any evaluation and management (E&M) services provided, the patient medical record includes appropriate documentation of the key components of the E&M service provided or supervised (e.g., patient history, physical examination, and medical decision making, as well

as documentation that adequately reflects the procedure or portion of the service performed).
- When supervising residents, physicians shall document they performed the services or were physically present when the resident performed key or critical portions of the services, and document their participation in managing the patient.

Any false, inaccurate or questionable claims are to be immediately reported to a direct supervisor, the Chief Compliance Officer, or a member of the Compliance Oversight Committee or Compliance Core Groups for further investigation.

Failure to comply with this or any other compliance policy may result in disciplinary actions per Samaritan policy.

**RELATED POLICIES**:
Corrections and Amendments to the Medical Record

**REFERENCES:**
45 CFR 164.530
Department of Health and Human Services
Office of Inspector General
Office of Medicaid Inspector General
Centers for Medicare and Medicaid Services

**REVIEWED:** 6/2013

**REVISED:** 7/27/09, 3/2018; 2/2022; 2/21/2023