

**Texas Tech University Health Sciences Center  
Billing Compliance Program**

<b>BCO 3.0 Coding and Documentation Improvement Program</b>	
<b>Approved Date:</b> March 13, 2008	<b>Effective Date:</b> April 1, 2008
<b>Last Revision Date:</b> March 18, 2010	

**A. PURPOSE**

To establish a means of improving the quality of coding and documentation of health care items/services provided by Texas Tech University Health Sciences Center (TTUHSC) employees (faculty, residents and staff) and contractors.

**B. POLICY**

TTUHSC providers are expected to strive for one hundred percent (100%) compliance with the billing documentation and coding requirements required by federal and state laws and regulations as well as private third party payer agreements.

A minimum of ten (10) encounters per year will be monitored for each provider who bills health care items or services under TTUHSC's tax identification number, focusing on the provider's unique billing/coding compliance risks. Current Providers shall be monitored in blocks of ten (10) encounters which shall be conducted and completed during an assigned calendar quarter. New and returning Providers shall be monitored within 60 days after their orientation pursuant to BCO 2.0.

**C. SCOPE**

This policy applies to all TTUHSC providers and coders/billers.

**D. PROCEDURE**

**1. Measuring Need for Participation in Improvement Program**

The Chart (Exhibit 1) should be used to identify who is responsible for errors identified during the monitoring and/or auditing process. The Chart corresponds to the Monitoring Face Sheet, Appendix A of the Monitoring Handbook which is used to track monitoring findings.

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**2. Provider Improvement Plan**

- a. TTUHSC providers who fail to perform within 100% of the compliance objective during a monitoring period (calendar quarter) will be required to participate in the improvement plan outlined below.

<b>POINTS</b>	<b>IMPROVEMENT PLAN</b>	<b>RESPONSIBLE PARTY</b>	<b>RESULTS</b>
0-2	a. Written notice to provider (Appendix B of Monitoring Handbook) of monitoring results	a. Clinical or Central Coding Department, or Billing Compliance Director Office (BCD)	Exceeds Expectations
3-6	a. Written notice (Appendix B) to provider of identified errors. b. As needed, meet with provider to answer questions.	a. Clinical or Central Coding Department, or BCD b. Clinical or Central Coding Department, or BCD	Meets Expectations
7-12	a. Written notice (Appendix B) to provider of errors.  b. Provide and document training on noted errors within a reasonable time.	a. Clinical or Central Coding Department, or BCD  b. Clinical or Central Coding Department, or BCD	Needs Improvement
13 or more	a. Written notice (Appendix B) to provider, copy to Department Chair, Administrator, and campus BCD. b. Provide training on identified errors within thirty (30) days of written notice. (May be extended as necessary.) Notify BCD when completed. c. If training not completed within the allotted time period, refer the matter to Department Chair for further action, copy to BCD. d. Audit of 10 encounters focused on problem areas identified in previous monitoring within thirty (30) days from training with written report to BCD. If no improvement refer the matter to Institutional Compliance Office for further action.	a. Clinical or Central Coding Department or BCD  b. Clinical or Central Coding Department or BCD  c. BCD and Department Chair  d. Clinical or Central Coding Department or BCD	Needs Significant Improvement

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- b. Refunds of Identified Overpayments. In all cases, the Department shall refund, as soon as possible, any over-payments identified during routine monitoring, follow-up audits required under the Provider Improvement Program, or any other audit or investigative activity.

**3. Non-Provider Employee Improvement Plan**

- a. Non-provider employees include any individuals who are responsible for selecting CPT codes, ICD-9 codes, modifiers and/or other information that is utilized to bill for health care items or services.
- b. In the event errors identified during the monitoring/auditing process due to a non-provider employee's errors resulting in twelve (12) or more points in a given calendar year, the Department shall work with the campus Billing Compliance Director to implement appropriate training to address the identified errors. It shall be the responsibility of the Clinical Department to provide appropriate training to the non-provider employee regarding any noted deficiencies totaling 12 or more points. This policy is neither structured nor intended to define a threshold for progressive disciplinary action. However, nothing herein shall prevent a Department from pursuing progressive discipline under TTUHSC's policies. Furthermore, nothing herein shall prevent the Billing Compliance Office from intervening when a Clinical Department fails or refuses to adequately address employee behavior resulting in health care billing non-compliance.
- c. It will be the responsibility of each Clinical Department to ensure that the Position Description Questionnaire (PDQ) of each non-provider employee described in C.1 includes the following:
  - 1) Function: accurate coding of health care items and services in accordance with TTUHSC's policies and applicable payer standards.
  - 2) Performance measures:
    - a) Points accumulated in billing compliance monitoring and/or auditing activities and applicable policies;
    - b) Internal or external audits or investigations that assess the accuracy of coding for health care items and/or services.

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**4. Fraudulent Behavior**

Fraudulent behavior or willful misconduct (e.g., falsifying documentation for billing purposes, etc.) will not be tolerated. Any employee (including faculty) engaging in fraudulent activity will be directed to the appropriate Institutional Compliance Committee and/or Dean for further disciplinary action, including, but not limited to, termination of faculty contract or employment, as may be applicable.

**E. ADMINISTRATION AND INTERPRETATIONS**

Questions regarding this policy may be addressed to the respective campus Billing Compliance Director or the Institutional Compliance Officer.

**F. AMENDMENTS OR TERMINATION OF THIS POLICY**

This policy may be amended or terminated at any time.

**G. CERTIFICATION**

I certify that this policy was approved by the Billing Compliance Committee, via e-mail vote.

*Mildred L. Johnson*

Mildred L. Johnson, J.D., CPC, CCEP  
Institutional Compliance Officer

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**Exhibit 1**

**CHART**

<b>Audit Findings</b>	<b>Category of Non-Compliance</b>	<b>Points</b>	<b>Responsible Party*</b>
A-1	Wrong CPT/HCPCS Code – Downcoded	0	P; C
A-2	Wrong CPT/HCPCS code, excluding E/M (Upcoded)	2	P; C
A-3	Modifier error, resulting in higher reimbursement	2	P; C
A-4	Service performed, but not a billable service (i.e., unbundling)	2	P; C
A-5	Service performed, but not billed	0	P; C
A-6	Billing for service(s) not provided	6	P; C; O
A-7	Modifier missing	0	C
B-1	Insufficient documentation of teaching physician's participation in service (i.e., no documentation, countersignature, etc.)	4	P
B-2	E/M service upcoded by one level (insufficient documentation)	2	P; C
B-3	E/M service upcoded by two or more levels	3	P; C
B-4	No documentation by provider for service coded or billed	6	P
B-5	Documentation does not support the code (other than E/M; example: anesthesia medical direction; time)	2	P
C-1	Diagnosis not accurate	0	P; C
C-2	No medical necessity exists	6	P
D-1	Wrong date of service (DOS)	1	P; C; O
D-2	Health care provider signature missing	1	P
D-3	Service billed under wrong provider	1	C; O
D-4	Advance Beneficiary Notice lacking	1	P; O
D-5	Services provided by unlicensed provider	6	P
D-6	Documentation not legible	3	P
D-7	Wrong place of service (POS)	2	C; O

**\*Responsible Party:**

P = Providers, including physicians/teaching physicians, physician assistants (PA), advanced registered nurse practitioner (NP), certified registered nurse anesthetists (CRNA), allied health providers

C = Coder/biller

O = Other factors as identified, such as Centricity error, data entry.