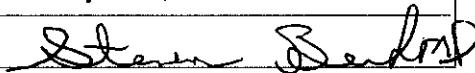


**Texas Tech University Health Sciences Center
Billing Compliance Program**

3.0 Policy on Coding and Documentation Improvement Program	
Approved Date: March 13, 2008	Effective Date: April 1, 2008
Last Revision Date:	Approved: 

A. PURPOSE

In accordance with the Texas Tech University Health Sciences Center (TTUHSC) Billing Compliance Program, to establish an effective means of improving the quality of coding and documentation of health care items/services provided by TTUHSC employees (faculty, residents and staff) and contractors to meet federal, state and private payer requirements.

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, focusing on the provider's unique billing/coding compliance risks. Providers shall be monitored in blocks of ten (10) encounters (a "monitoring block"). A provider's monitoring block shall be conducted and completed during an assigned calendar quarter.

C. SCOPE

This policy shall apply to all TTUHSC providers who bill health care items or services under a TTUHSC tax ID number.

D. PROCEDURE

1. Measuring Need for Participation in Improvement Program

The chart attached as Exhibit 1 (Chart) 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.

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.

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POINTS	IMPROVEMENT PLAN	RESPONSIBLE PARTY
1-6	a. Notify provider (Appendix B of Monitoring Handbook) of any deficiencies noted.	a. Clinical Department and/or Central Coding Department
7-12	a. Written notice (Appendix B) to provider of deficiencies noted. b. Provide and document training on noted deficiencies within a reasonable time.	a. Clinical Department and/or Central Coding Department b. Clinical Department and/or Central Coding Department
13 or more	a. Written notice to provider of deficiencies noted (Appendix B), copy to Department Chair and Administrator, and Billing Compliance Office. b. Provide training on noted deficiencies within thirty (30) days of written notice. (May be extended as necessary.) Notify Billing Compliance Office when completed. c. If training not completed within the allotted time period, refer the matter to Department Chair for further action, copy to Billing Compliance Officer. d. Prospective audit of 10 encounters within thirty (30) days from training with written report to Billing Compliance Office. If no improvement refer the matter to Billing Compliance Office for further action.	a. Clinical Department, Central Coding Department or Billing Compliance Office b. Clinical Department, Central Coding Department or Billing Compliance Office c. Billing Compliance Office and Department Chair d. Clinical Department or Central Coding Department

- 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 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 there are errors identified during the monitoring/auditing process due to a non-provider employee's

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errors resulting in twelve (12) or more points in a given calendar year, the Department shall work with the Billing Compliance Office 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 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 BCO monitoring and/or auditing activities and applicable policies;
 - b) Internal or external investigations that assess the accuracy of coding for health care items and/or services.

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 Billing Compliance Officer or the Institutional Compliance Officer.

F. AMENDMENTS OR TERMINATION OF THIS POLICY

This policy may be amended or terminated at any time.

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Exhibit 1

CHART

Audit Findings	Category of Non-Compliance	Points	Responsible Party*
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; S
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 document)	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; S
D-2	Health care provider signature missing	1	P
D-3	Service billed under wrong provider	1	C; S
D-4	Advance Beneficiary Notice lacking	1	P; S
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; S

***Responsible Party:**

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

C = Coder/biller

S = Other staff as identified.