POLICY AND PROCEDURE

REACH for Tomorrow

Title: Billing Compliance Policy

Effective Date: 07/01/2025

Approved By: Executive Director

Review Schedule: Annually or as Needed

Applies To: All Programs and Locations — Outpatient MH/SUD, IOP, Integrated Behavioral Health/Primary Care, and PHP

I. Purpose

The purpose of this Billing Compliance Policy is to ensure that all billing practices at REACH for Tomorrow comply with applicable federal, state, and payer regulations, including those set forth by Centers for Medicare & Medicaid Services (CMS), Ohio Medicaid, commercial insurers, and CARF standards. This policy promotes integrity, accuracy, and transparency in all billing and reimbursement processes and supports the prevention, detection, and correction of errors or potential fraud.

II. Scope

This policy applies to all staff involved in documentation, coding, billing, and reimbursement processes, including clinicians, administrative and billing staff, supervisors, and the contracted billing vendor, Level Billing, who performs billing and payer enrollment services on behalf of the organization.

III. Policy Statement

REACH for Tomorrow is committed to conducting all billing and reimbursement activities in an ethical, lawful, and compliant manner. All claims submitted must be accurate, properly documented, and supported by complete and timely clinical records. Fraudulent, abusive, or wasteful billing practices are strictly prohibited. The organization maintains internal controls and oversight to ensure compliance with payer guidelines, contractual requirements, and applicable laws.

IV. Responsibilities

Director of Medical and Clinical Services: Oversees the organization's billing compliance program and ensures policies align with CARF standards, Ohio Medicaid rules, and payer contracts.

Compliance Officer: Conducts periodic internal audits, coordinates compliance training, investigates suspected billing issues, and ensures corrective actions.

Billing Vendor – Level Billing: Submits claims in accordance with payer requirements, ensures coding accuracy, provides monthly reports, resolves denials, and communicates payer updates.

Clinical and Administrative Staff: Ensure all documentation accurately reflects services rendered, complete documentation before claims submission, and report any compliance concerns.

V. Billing Standards and Requirements

1. Service Documentation: All billed services must be supported by clinical documentation that includes date, duration, and type of service. Notes must be completed within 24–48 hours.

2. Coding Accuracy: CPT, HCPCS, and revenue codes must accurately reflect services provided. Add-on codes must be justified by documentation.

3. Provider Credentialing: Services may only be billed under credentialed and enrolled providers. Claims must reflect correct rendering and supervising provider identifiers.

4. Client Eligibility and Authorization: Client eligibility for coverage must be verified prior to billing. Preauthorization requirements must be met as required by payers.

5. Prohibited Practices: Billing for services not rendered or documented, altering documentation, double billing, or misrepresenting services is strictly prohibited.

6. Refunds and Adjustments: Overpayments will be refunded promptly within required timeframes once identified.

VI. Audit and Monitoring

The Compliance Officer and Level Billing will conduct quarterly billing audits to verify the accuracy of claims and supporting documentation. Findings and recommendations will be reviewed by the Executive Director, and corrective actions will be implemented where necessary.

VII. Reporting and Investigation of Concerns

Staff must report any suspected billing errors, irregularities, or violations to the Compliance Officer or Executive Director immediately. Reports may be made confidentially without fear of retaliation. The Compliance Officer investigates and documents findings, initiates corrective actions, and reports as required by law.

VIII. Training and Education

All staff involved in billing, documentation, or coding must complete compliance training at onboarding and annually thereafter. Training includes documentation standards, coding and billing accuracy, fraud and abuse prevention, and ethical responsibilities. Attendance and competency verification are maintained in training records.

IX. Record Retention

Billing and reimbursement records, including claims, remittance advice, audit reports, and supporting documentation, will be retained for a minimum of seven (7) years or as required by law and payer contracts.

X. Corrective Action and Enforcement

Noncompliance with this policy may result in disciplinary action up to and including termination. When errors or overpayments are identified, corrective actions will include claim correction, refund, and staff retraining. The organization will fully cooperate with payer audits or regulatory reviews.

XI. Continuous Quality Improvement (CQI)

Billing and documentation processes will be reviewed annually as part of the CQI program. Audit outcomes and payer feedback will guide ongoing training and improvements in compliance procedures.

XII. Policy Review and Approval

This policy will be reviewed annually by the Executive Director and Compliance Officer to ensure continued compliance with applicable laws, payer updates, and CARF standards.

Approved By: Leslie M Stegall MSN, APRN, NP-C, PMHNP-BC

Title: Director of Medical and Clinical Services

Date: 07/01/2025