Evolution HEALTH	Policy No.: 409	Signature:	
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BILLING FOR ONLY MEDICALLY APPROPRIATE CARE

CORPORATE ETHICS & COMPLIANCE DEPARTMENT

SCOPE:

All Evolution Health colleagues. For purposes of this policy, all references to "colleague" or "colleagues" include temporary, part-time and full-time employees, independent contractors, clinicians, officers and directors.

PURPOSE:

The purpose of this Policy is to set forth the general guidelines established by Evolution Health (the "Company") to ensure the appropriateness of services provided to home health patients.

POLICY:

It is Company policy to ensure the appropriateness of services provided to patients and the accuracy of every claim processed and submitted.

PROCEDURE:

Review of Clinical Records

- The Company routinely will review clinical records (both prior and subsequent to billing for services) as a means of ensuring that patients are receiving only medically necessary services.

- Prior to submitting a claim for payment, the Company shall verify that all documentation for services reflected on the claim, such as physician orders and certificates of medical necessity, are available in a proper and timely manner. The Company shall submit claims only when appropriate documentation supports the claim and only when such documentation is maintained and available for audit and review.

    1. Documentation, which serves as the basis for a claim, must be appropriately organized in legible form so that such documentation may be audited and reviewed.

    2. Diagnoses and procedures reported on reimbursement claims must be based on the patient's medical record and other documentation.

3. Documentation must verify that the patient received the appropriate level and number of services.

Claim Submissions and Cost Reporting

- The Company has an obligation to its patients, third party payors, and state and federal health care programs to exercise diligence, care, and integrity when submitting claims for payment. It is the Company's policy that claims must:

  1. Be accurate and timely submitted; and

  2. Be only for services or items that are:

     - Medically necessary;

     - Fall within the coverage guidelines contained in applicable laws, rules, and regulations; and

     - Are documented in the client's medical record.

- Documentation necessary for accurate code assignment must be made available to all employees with coding responsibility. Compensation for billing department coders and billing consultants shall not provide for any financial incentive to improperly upcode claims.

- Cost reports must be prepared utilizing generally accepted accounting principles based upon documents and reports that are maintained in the Company's day to day business. Cost reports must document only those costs which the Company's employees and/or agents believe in good faith are allowable.

- The following conduct is specifically prohibited with regard to claim submissions and cost reporting:

  1. Claims for payment or reimbursement of any kind that are false, fraudulent, inaccurate or fictitious;

  2. Falsified medical records, time cards or other records used as the basis for submitting claims;

  3. For services that must be coded, use of a code that does not accurately describe the documented service when there is a more accurate code that could have been used. This includes post-dating orders or signatures. Late entries should include an explanation of reason for delay in entry;

4. Bills submitted to Medicare, Medicaid, or applicable insurance plan for items or services, which are known to not be covered;

5. Filing claims for the same item or service to more than one payor source whereby the Company will receive duplicate or double payments;

6. Submission of claims without the availability of adequate documentation;

7. Falsification of any report or document used to document the cost of utilization of services by payor source;

8. Failure to report a known error or inaccuracy in any cost report or underlying document used to prepare a cost report; and

9. Recording inappropriate, inaccurate, or non-allowable costs on a cost report.