DOCUMENT TITLE: Billing Compliance Policy	SYSTEM POLICY AND PROCEDURE MANUAL
POLICY #: 800.50	**CATEGORY:** Compliance & Ethics
System Approval Date: 07/22/2025❖ **Site Implementation Date:** 07/22/2025❖	**Origination Date**: 11/2012 **Previously Reviewed/Approved:** 02/2025
Prepared by: Office of Corporate Compliance	**Notations:**

GENERAL STATEMENT of PURPOSE

The purpose of this document is to affirm the commitment of Northwell Health to ensuring that its billing practices comply with applicable federal and state laws, regulations, guidelines and policies.

POLICY

It is the policy of Northwell Health that in an effort to comply with applicable federal and state law, Northwell Health has billing standards and procedures that assist in ensuring that claims are timely, accurate and complete. To prevent the submission of erroneous billing claims, this policy also provides guidance to employees on certain key risk areas that affect billing for health care services.

SCOPE

This policy applies to all Northwell Health employees, as well as medical staff, volunteers, students, trainees, physician office staff, contractors, trustees and other persons performing work for or at Northwell Health; faculty and students of the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell or the Hofstra Northwell School of Nursing and Physician Assistant Studies conducting research on behalf of the Zucker School of Medicine on or at any Northwell Health facility; and any other Affected Individual.

DEFINITIONS

Affected Individuals: "Affected Individuals" is defined as all persons who are affected by Northwell Health's risk areas including, but not limited to, Northwell Health's employees, the chief executive and other senior administrators, managers, medical staff members, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.

Government Healthcare Programs are defined as any healthcare program so defined under 42 U.S.C. § 1320a-7b(f) or any other federal, state or locally funded healthcare program, including, but not limited to, Medicare fee-for-service ("FFS"), Medicaid FFS, managed Medicare/Medicaid, TRICARE, CHAMPVA or the Children's Health Insurance Program.

Overpayment means the amount of money Northwell Health has received in excess of the amount due and payable under any Government Healthcare Program requirements, including but not limited to applicable statutes, regulations, Medicare, Medicaid or other federal or state healthcare program payment manuals, Medicare fiscal intermediary or carrier Local Coverage Decisions, and the National Correct Coding Initiative. Overpayments do not include payments from Government Healthcare Programs that, in a timely manner, are repaid, voided, canceled, or otherwise reversed through routine claims reconciliation.

PROCEDURE

BILLING

1. The goal for any claim submission is 3 days from the service date. In order for inpatient cases and certain outpatient services to bill, the patient's medical chart is reviewed by Northwell Health's coding staff to ensure that the documentation supporting all claims is complete, accurate and reflects reasonable and necessary services, and that the proper diagnosis/procedure codes are added to the patient 's account.

2. At the time of billing, the account must pass through a series of edits that have been built into Northwell Health's Patient Accounting systems. These edits are designed to prevent potential billing errors.

MEDICARE

3. Medicare billing is done electronically and on a daily basis. If a claim was not received by Medicare, the biller researches why. Some reasons why the claim may not have been received by Medicare are as follows: the claim hit an Outpatient Code Editor (OCE) edit in the hospital billing system; the claim was missing required information; or the claim had a manual bill hold on it. Once the issue is identified, the biller corrects it and resubmits the claim to Medicare, if appropriate.

4. On a daily basis, the Medicare billers also access claims corrections on Medicare's system to ensure that any claim that edited in Medicare's system is being researched and worked.

   Medicare follow-up is conducted on any account that was not paid correctly and is researched and re-billed for correct payment, if appropriate.

MEDICAID

5. Medicaid billing is done daily. If a claim was not received by Medicaid, the biller researches why. Some reasons why a claim may not have been received by Medicaid are as follows: the claim required information or the claim had a manual bill hold on it. Once the issue is identified, the biller corrects it and resubmits the claim to Medicaid, if appropriate.

Medicaid follow-up is conducted on any account that was not paid correctly is researched and re-billed for correct payment, if appropriate.

COMMERCIAL

6. For all Hospitals, commercial insurance and managed care claims first qualify for follow-up 21-45 days from the initial billing of the claim depending on the dollar amount of the claim. Follow-up calls are placed every 10-18 days to confirm that the claim has been received and to confirm that the carrier has all required documentation needed to process the claim.

FINANCIAL ASSISTANCE UNIT (FAU)

7. If the patient states that he or she cannot afford to pay for the services, the patient will be referred to the FAU to determine whether he or she qualifies for financial assistance.

CHARGE ENTRY DOCUMENTATION

8. The Chargemaster shall be regularly updated with the most current guidelines for Healthcare Common Procedural Coding System (HCPCS) codes, Current Procedural Terminology (CPT) codes, and revenue codes. These codes must accurately describe the services ordered by the appropriate provider. Billing personnel must immediately report any unresolved issues or questions regarding charge entry documentation to their supervisor, manager or the Director of Compliance.

UNBUNDLING

9. The use of billing individual codes for services that have been assigned an aggregate billing code (i.e., unbundling) is prohibited.

CREDIT BALANCES AND OVERPAYMENTS

10. The Central Business Office will review credit balances for errors such as overpayments by an insurance company and/or another responsible party, duplicate payment/contractual entries, misapplied charges/credits and incorrect patient account adjustments. Once this review is performed, all confirmed overpayments must be refunded to or retracted by the applicable payors. For more detailed information on refunding credit balances to commercial insurance companies, please refer to Northwell Health's "Credit Review/Refund" policy.

11. All Overpayments must be refunded and appropriately reported to the applicable federal and state payors within 60 days after identification or within such additional time period as may be agreed to by the payor. The corrective action will include correcting the underlying cause of the overpayment and taking remedial action to prevent the overpayment from recurring. *See Northwell Health Policy #800.07- Compliance with Government Funded Healthcare Claims and Cost Reporting Requirements.*

BALANCE BILLING

12. Northwell Health is prohibited from knowingly collecting or attempting to collect from any patient the difference between the total charges and what is contractually covered by a contracted insurer

health plan, except for patient co-pay, co-insurance and deductible amounts for which the patient is accountable pursuant to the plan's benefit design. Balance billing may be appropriate and permissible for patients covered by non-contracted payers in accordance with the NY State Emergency Services and Surprise Bill Law, Connecticut No Surprise Act, as well as the Federal No Surprise Act.

DUPLICATE BILLING

13. Billing staff must not knowingly submit more than one claim for the same services and knowingly submitting the same claim to more than one primary payor is prohibited.

BILLING FOR DISCHARGE IN LIEU OF TRANSFER

14. Northwell Health shall ensure that the appropriate discharge disposition code is assigned in order to receive correct reimbursement from the payor.

IDENTIFICATION OF BILLING DISCREPANCIES

15. In the event a discrepancy is discovered subsequent to the submission of the claim, all attempts to void the claim or submit an adjusted claim, as appropriate, must be made in order to submit the correct claim for the services provided. Either each facility or the central billing office must undertake the appropriate investigation to determine the root cause(s) of the discrepancy and work promptly to correct any adverse result of the variance.

MEDICARE SECONDARY PAYOR

16. Northwell Health's applicable facilities will ask each patient or his/her representative questions concerning the patient's health insurance and/or Medicare coverage status to determine whether Medicare is the primary payor for those services or items. Finance will determine payment priority in a manner that complies with applicable laws and regulations, including, without limitation, the Medicare Secondary Payer (MSP) provisions, and will not knowingly submit claims to payors, plans, and/or programs in the incorrect order of financial liability or bill Medicare as the primary payor where, by law and pursuant to the MSP provisions, it is the secondary payor.

BILLING EMPLOYEES: TRAINING AND COMPLIANCE

17. Employees are expected to share the responsibility for upholding company standards as well as billing standards. All billers receive training on applicable billing topics on a regular basis and must meet billing continuing education obligations. The Finance Department will maintain and make available to billing staff documentation of billing guidelines or billing requirements for the appropriate payor.

MONITORING AND AUDITING TO DETECT AND PREVENT BILLING DISCREPANCIES

18. Billing quality reviews will be performed periodically by representatives in Patient Accounts to ensure compliance with billing policies and applicable state and federal law. If any material billing issue is identified, billing staff must contact the Office of Corporate Compliance. The Office of

Corporate Compliance will investigate such material billing issues and, if appropriate, work with the appropriate department(s) to resolve the issue. Such steps include, but are not limited to, revising existing policies, changing staffing, remediating claims made in error and facilitating education sessions.

19. Northwell Health will perform routine audits by internal or external auditors who have expertise in the state and federal Medical Assistance program requirements and applicable laws, rules and regulations, or have expertise in the subject areas of the audit. Northwell Health audits the claims and cost reports, the processes used to develop and submit claims and cost reports, and the underlying or supporting documentation. Any Overpayment will be handled in accordance with Northwell Health's internal procedures and shall be reported and returned in accordance with applicable payor/agency requirements. Any Government Healthcare Programs Overpayment shall be reported and returned by the later of (i) 60 days following the identification of the Overpayment, and (ii) the date any corresponding cost report is due, if applicable.

20. The results of all internal or external audits, or audits conducted by the State or Federal government shall be reviewed for risk areas that can be included in updates to Northwell Health's Compliance Program and Compliance Work Plan.

21. The design, implementation, and results of any internal or external audits shall be documented, and the results shared with the Executive and Audit Compliance Committee and the Audit and Corporate Compliance Committee of the Board.

BILLING FOR PHYSICIANS WHO ARE NOT YET CREDENTIALED

23. Providers who are recently employed by Northwell Health, but are awaiting the credentialing process may not submit claims for services. Once credentialed, billing for services rendered may commence.

24. Once credentialed, providers may not retrospectively bill Medicare/Medicaid beyond the permissible time period, as determined by the effective date of their enrollment. Providers are referred to their specific agreements with commercial insurers to determine whether they may bill retrospectively.

BILLING FOR CLINICAL RESEARCH STUDIES

25. For billing pertaining to clinical research studies or trials please refer to and follow procedures in *Policy #GR023- Billing Procedure for Outpatient Services, Inpatient Services and Ancillary Testing in Clinical Research Protocols.*

REPORTING AND ENFORCEMENT

All violations of this policy shall be reported to the appropriate manager/supervisor/director or to the Office of Corporate Compliance (516-465-8097) for appropriate resolution of the matter. The HelpLine is available 24 hours a day, seven days a week at (800) 894-3226 or online at www.northwell.ethicspoint.com, is accessible to all Affected Individuals and allows for questions regarding compliance issues to be asked and for compliance issues to be reported. Reports of potential fraud, waste and abuse and compliance issues also may be made directly to the Chief Corporate Compliance Officer or designee in person, in writing, via email, mobile device via a QR code, or by telephone. All reports received by the Office of Corporate Compliance are investigated and resolved to the fullest extent possible. The confidentiality of persons reporting compliance issues shall be maintained unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by Medicaid Fraud Control Unit, Office of Health and Human Services, U.S. Department of Health and Human Services (HHS) Office for Civil Rights, HHS Office of Inspector General, Office of Medicaid Inspector General or law enforcement, or disclosure is required during a legal proceeding, and such persons shall be protected under the required provider's Northwell Health's policy for non-intimidation and non-retaliation. Violations of this policy will be subject to disciplinary action as outlined in the Human Resources Policy and Procedure Manual and *Northwell Health Policy #800.73 – Compliance Program Disciplinary Standards for Non-Employees*.

REFERENCES to REGULATIONS and/or OTHER RELATED POLICIES

- Northwell Health Policy #800.07- Compliance with Government Funded Healthcare Claims and Cost Reporting Requirements
- Northwell Health Policy #800.73 – Compliance Program Disciplinary Standards for Non-Employees
- Northwell Health Human Resources Policy and Procedure Manual, Part 5-3 – Workforce Conduct – Progressive Discipline
- Northwell Health Policy GR023 – Billing Procedure for Outpatient Services, Inpatient Services and Ancillary Testing in Clinical Research Protocols
- New York State, Medicaid Program, Information For All Providers, General Billing: https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Billing.pdf
- OMIG Compliance Program Guidance, Title 18 NYCRR, Part 521 Fraud, Waste and Abuse Prevention (March 28, 2023) https://omig.ny.gov/information-resources/laws-and-regulations#Regulatory%20Activity
- 4 NYCRR § 830: Designated Services
- 14 NYCRR § 596: Telehealth Services

- Connecticut No Surprise Act; Conn. Gen. Stat. §§ 38a-477aa & 20-7f
- Connecticut Telehealth Services; Conn. Gen. Stat. §§ 19a-906, 38a-499a & 38a-526a

CLINICAL REFERENCES/PROFESSIONAL SOCIETY GUIDELINES
N/A

ATTACHMENTS
N/A

FORMS
N/A

CURRENT REVIEW/APPROVALS:	
Service Line/Department Review	07/03/2025
Northwell Health Policy Committee	07/22/2025❖
System PICG/Clinical Operations Committee	07/22/2025❖

Standardized Versioning History:
Approvals: * =Northwell Health Policy Committee; ** = PICG/Clinical Operations Committee; ✠ = Provisional; ❖ = Expedited
10/25/12* 11/15/12**
8/25/16* 09/15/16**
✠09/20/18
10/25/18* 11/26/18**
11/19/20* 12/10/20**
11/23/22* 12/15/22**
❖03/28/23
02/27/24* 03/21/24**
01/21/25* 02/24/25**