

Corporate Compliance Program



Adventist Health Compliance Program 2007 Overview

Overview: Adventist Health (AH) established the corporate compliance program in 1996. It has been developed and expanded to include 7 parts to address the various compliance risk areas, e.g., contracts, home health, laboratories, billing, health information management, and hospital based physician clinics. (See attached).

Purpose: To establish and integrate policies and procedures that will help AH facilities abide by the government regulations. The compliance program primarily addresses reimbursement related issues, while recognizing there are many regulations that impact the delivery of health care services and are managed by other departments within AH (e.g., Patient Care, JCAHO, Human Resources, OSHA, Hazardous Waste, etc).

Corporate Compliance: The compliance program is managed by the AH Corporate Compliance Department in Roseville, California. Douglas E. Rebok, the Corporate Compliance Officer, and Kevin Longo, the Director of Corporate Compliance oversee it from the Corporate Office. In addition, each facility has a designated Local Compliance Officer who is responsible for compliance oversight at the local level.

The Corporate Compliance Department manages the overall compliance program, manages the AH compliance reporting operations, investigates reported violations, and conducts monitoring and auditing activities to evaluate the effectiveness of the organization's compliance activities.

The Compliance Department performs the following activities:

Maintains a Summary of the Compliance Program: The Adventist Health Internet site at <http://www.adventisthealth.com/aboutus/> describes our compliance program and includes a copy of the compliance program, code of conduct and local compliance officer contact lists. In addition, under the "Contact Us" link a list of our compliance reporting options is available along with a compliance report form that individuals may use to report issues to us.

Sanctioned Individuals: Compares all employees, physicians, and vendors to the Office of Inspector General (OIG), Government Services Administration (GSA), and the California Department of Health Services (DHS) sanctioned, debarred and ineligible databases at least annually.

Laboratory 30 Analysis: Works with the facilities to identify and evaluate the 30 most frequently used laboratory tests and determine the reason for any increases greater than 10% from year to year.

Referral Source Contract Audits: Compliance department staff conduct audits of each facility's referral source contracts. The purpose of the audit is to ensure that facilities are processing these contracts in accordance with AH policy and approval procedures. The audits involve all referral source contracts and medical directorship arrangements. Each hospital is audited once every three years.

Compliance Program Review: The department conducts extensive onsite reviews of each facility's adherence to the AH compliance program. The reviews typically consist of interviews with each department that is considered to be responsible for components of the compliance program. Departments typically reviewed include, Accounting, Emergency Department, Labor & Delivery, Health Information Management, HIPAA Privacy, Home Health Agency, Human Resources, Clinical Laboratory, Medical Staff, Patient Financial Services, and compliance education. Each facility is reviewed every other year.

DRG Audits: The Compliance Department works in conjunction with the HIM Department to ensure that inpatient and outpatient coding audits are completed on a quarterly basis. These audits may be completed internally or contracted out to third party coding consultants. These audits typically focus on DRGs that Government sources have identified as susceptible to Upcoding from sources such as the OIG Workplan, PEPPER data, RAC audits, and codes identified internally as problematic.

Compliance Reporting: The Compliance Department manages a toll-free "Hotline" that individuals have access to 24 hours per day to report issues or activities that may violate government regulations. The toll-free # is 1-888-366-3833. Reports may be made on "Compliance Report Forms", through supervisors, local compliance officers, and via the mail to the corporate office.

Investigates Compliance Reports: The Compliance Department logs all compliance issues brought to its attention, investigates, tracks, and monitors them to ensure that they are resolved and self-disclosed (as necessary) in an appropriate manner.

Compliance Research Activities: The Compliance Department is available to perform research for compliance related topics and issues. If the department is unable to perform the research they will work with the facilities to locate a suitable source for obtaining assistance in the matter.

Compliance Policies: The Compliance department works collaboratively with the Administration, Patient Financial Services, Health Information Management departments, HIPAA Privacy and Security, and Risk Management departments to ensure that AH Affiliates have system-wide policies available comply with the numerous regulatory requirements we are expected to follow. These policies may be found on the Connect on the following department web sites:

Patient Financial Services in the Policy and Procedure Manual,
Health Information Management, and
HIPAA

Compliance Resources Available to AH Facilities:

Latham & Watkins: Outside general counsel.

Commerce Clearing House (CCH) Online Resource: – 5 Users/2 concurrent users. This resource is available by requesting research assistance from the Budget/Reimbursement department. The following are CCH products available through this website resource:

- Medicare/Medicaid Guide
- Health Care Compliance Portfolio
- California State Laws & Regulations
- CMS Program Manuals
- CPT/CCI Codes
- Physician Medicare Part B Explained
- Home Health Medicare and Medicaid Payment Library
- Understanding CHAMPUS
- Topical Indexes

MediRegs ComplyTrack: This is a product licensed by the the AH Corporate Compliance Department. It provides various tools to assist in our system-wide compliance activities, including,

- Activities and Event Manager,
- Contract management database,
- Risk Assessment Manager, and
- MediRegs Reference Portal.

Report on Medicare Compliance: This is a compliance newsletter. AH obtained a group subscription for this newsletter from AIS Publishing. Each facilities' Local Compliance Officer receives a hardcopy and e-mail copy on a weekly basis. We ask that the hardcopy be circulated among each facility's administration.

SLG Consulting, Inc.: Adventist Health contracts with SLG Consulting for assistance with various billing and charge-master issues. The Corporate PFS department contracts with SLG, Inc. to provide this resource. SLG, Inc. receives billing and compliance questions via e-mail at AskSLGInc@aol.com or by calling 916 387-5960. They respond in 24 hours, Monday through Friday.

Associations:

Health Care Compliance Association (HCCA):
<http://www.hcca-info.org/>

Healthcare Financial Management Association (HFMA):
<http://www.hfma.org/>

American Health Information Management Association (AHIMA):
<http://www.ahima.org/>

Journals:

Healthcare Financial Management a publication of HFMA

Journal of Health Care Compliance by Aspen Law & Business

Compliance Today by HCCA

Attached in this section are copies of:

AH Compliance Department Charter
Mission and Vision Statement
2002 3-5 Year Strategic Intents
Code of Conduct brochure

Corporate Compliance Department Charter

In furtherance of the Adventist Health Corporate Compliance Program, Adventist Health establishes the Corporate Compliance Department, to provide oversight to the Compliance Program. The responsibilities of the department are:

- Develop, expand, and coordinate the corporate compliance program.
- Monitor legislation involving compliance-related issues, such as, physician contracting, patient billing, coding, etc.
- Collect, review, and prepare physician contract information for presentation to Adventist Health's Board Compliance Committee.
- Establish, oversee, monitor, and maintain the internal corporate compliance reporting process to ensure Adventist Health employees and agents can report ethics and compliance concerns without fear of retaliation. Ensure reported concerns are promptly and thoroughly investigated. Periodically summarize reporting activities to the Corporate Compliance Officer for presentation to Adventist Health's legal board and/or its' appointed subcommittee.
- Participate in the communication, development of training material and programs to 1) convey Adventist Health's Code of Conduct to all employees, 2) periodically refresh employees' knowledge of the Code of Conduct, and 3) address areas of compliance risk concerning specific employee populations.
- Participate in the process of ensuring that internal control systems are capable of detecting significant instances or patterns of illegal or unethical conduct by employees or agents.
- Provide technical support and consultation to local compliance officers and interface with corporate counsel in determining appropriate responses to compliance violations.
- Provide consultative services to AH Affiliate patient financial services departments to promote compliance with regulatory requirements, and improve and enhance efficient billing operations.
- Provide technical support to Adventist Health Affiliate departmental managers by researching compliance related issues that affect their department operations.

The department shall be led by the "Director, Corporate Compliance" (Director), at the corporate offices of Adventist Health. The Director shall report to the Senior Vice President of Finance/Corporate Compliance Officer. The Director shall keep the Corporate Compliance Officer apprised of current activities and make periodic reports to the Adventist Health Legal Board regarding the status of the Compliance Program.

The Department shall meet its responsibilities by establishing and following annual goals and objectives designed to carry out the purposes of the Adventist Health Compliance Program. The departmental goals and objectives will include tangible measures designed to document the effectiveness of the department's endeavors. The Department shall establish such goals based on the requirements of the AH Corporate Compliance Program, issues raised at the various Adventist Health Affiliates, information and publications from governmental agencies, industry trade organizations, and corporate legal counsel.

The Department shall work with the Regional and Local Compliance Officers to support them in carrying out the Adventist Health Corporate Compliance Program in their local facilities. The Department shall monitor compliance related issues that affect various departments of Adventist Health Affiliates and communicate such issues to the AH Affiliate Departmental directors. The Department will work collaboratively with all Adventist Health departments that are impacted by the organization's compliance program (e.g., Budget/Reimbursement, Information Systems, Risk Management, Communications, etc.)

Corporate Compliance Department

Mission Statement:

The Corporate Compliance Department is a team of professionals helping fulfill the Adventist Health Mission by supporting ethical standards and practices throughout the organization's business units and functioning as consultants to departments that affect claims submission.

The Vision Statement:

Our vision of the future is based on an understanding that the entire health care industry is facing increased pressures through regulations and litigation from government agencies, third-party payors, and the general public to operate with the highest levels of accuracy and eliminate erroneous and false claims. The Corporate Compliance department will deliver superior service to its key customers and will earn their respect by providing education and support. The department will help them understand the importance and necessity of implementing policies, procedures and practices that will help effectively and economically comply with regulatory requirements.

Key Stakeholders:

Adventist Health Board of Directors
Board Compliance Committee
Adventist Health Senior Leadership
Corporate Compliance Officer

Key Internal Customers:

Regional Compliance Officers
Local Compliance Officers
Facility Chief Executive Officers and Chief Operating Officers
Patient Care Executives
Contract Coordinators
Patient Financial Services Directors & Managers
Ancillary/Clinical Managers
Home Health Directors and Managers
Health Information Directors & Managers (Medical Records Managers)
Risk Managers
Medical Foundations
Hospital Based Clinics
Rural Health Clinics

Key External Customers: (Key Suppliers/Contractors)

Latham & Watkins (External Counsel)
Ernst & Young (External Auditors)
Medicare Fiscal Intermediaries and Carriers
CMS and other Regulators
Consultants

**PRIVILEGED AND CONFIDENTIAL
ATTORNEY-CLIENT COMMUNICATION
ATTORNEY WORK PRODUCT**

Adopted September 22, 1997

**ADVENTIST HEALTH
Corporate Compliance Program**

PART 1: Compliance Standards, Policies and Procedures

WARNING! This document is the private property of AH and its Affiliates. Some sections of this Compliance Program are provided to our employees as part of their employee education and to assure that this Program is understood and followed. This document contains confidential and proprietary information. It is not the property of any individual employee. No part of this Program may be copied or shown to anyone not directly employed by AH or one of its Affiliates without the written consent of the Corporate Compliance Officer. Independent contractors of AH or its Affiliates may be shown part of or all of the Program on a “need to know” basis, if approved in advance by the Corporate Compliance Officer and if the independent contractor covenants to maintain the confidentiality of the Program’s content and all related documents.

I.
INTRODUCTION TO THE PROGRAM

Adventist Health (“AH”) has established this Corporate Compliance Program (“Program”) for the employees and independent contractors (hereafter collectively referred to as “employees”) of AH and any organization controlled by AH (an “AH Affiliate”)¹ who is or may be involved in an activity governed by the Program (“affected employees”).

The Program has multiple parts. Part I sets forth a code of conduct, standards and procedures for all corporate activity. Part II sets forth contract guidelines and approval guidelines for an AH Affiliate to enter into an agreement with any physician or other person who refers business to the AH Affiliate. Part III sets forth guidelines for the operation of AH home health agencies and hospice programs. Part IV sets forth guidelines for the operation of AH clinical laboratories. Part V sets forth guidelines for the clinical and diagnostic coding of AH patient records. Part VI sets forth guidelines for the operation of AH patient billing offices. Part VII sets forth guidelines for the operation of AH hospital based physician practices. Part VIII sets forth guidelines for the operation of AH Medical Foundations.

II.
PURPOSE OF AH

AH is a nonprofit, religious corporation that controls numerous provider organizations in the Western United States. AH’s mission is to be a family of caring people reaching out to those in need. We follow the example of Christ by being creative partners with and servants to the communities whose quality of life and health we seek to advance. AH and its Affiliates are dedicated to serving their communities. Affiliates provide high quality health care services in a manner that is consistent with their charitable and religious missions.

The health care industry is undergoing significant changes. Federal and state laws governing health care providers attempt to keep pace with these changes, and they have become increasingly complex as a consequence. AH and its Affiliates are committed to conducting business activities in compliance with all applicable laws, rules, and regulations. Management and employees are dedicated to high ethical standards, and recognize their duty to conduct all business within the bounds of the law.

III.
POLICIES AND PROCEDURES

A. Code of Conduct.

Each employee shall be subject to and shall comply with the standards set forth in the AH Corporate Code of Conduct attached as Attachment 1.1 (the “Code of Conduct”).

¹ Any action taken by that organization, including clinics, joint venture actions agreed to by the organization, etc..

B. Distribution of the Code of Conduct.

Relevant portions of the Program, including the Code of Conduct, shall be sent to each affected employee. In addition, the Code of Conduct shall be included in the Employee Handbook so that all employees will receive a copy of the Code of Conduct. All affected employees who receive the Code of Conduct shall execute a statement in the form of Attachment 1.2 affirming that they have received and reviewed the Code of Conduct. In addition, all senior executives and others designated by the Corporate Compliance Officer shall execute a statement in the form attached as Attachment 1.2 once a year at their annual review.

C. Compliance Officers.

AH shall appoint a Corporate Compliance Officer. In addition, the President of each AH Affiliate shall designate a local compliance officer for such AH Affiliate. Each local compliance officer shall be a person with an appropriate position, sufficiently educated and trained, who shall be given the necessary authority and responsibility to implement this Program. The Corporate Compliance Officer and each local compliance officer shall be responsible for implementing, overseeing and enforcing all aspects of the Program. A list of the current Corporate Compliance Officer and the local compliance officers is set forth in Attachment 1.3, which shall be updated as necessary.

The Corporate Compliance Officer shall coordinate with each local compliance officer to uniformly implement the Program. All compliance officers will coordinate their activities with legal counsel (“Counsel”) as set forth in this Program.

The identity of each AH Affiliate’s local compliance officer shall be disseminated to all affected employees in conjunction with the dissemination of this Program, and shall be publicized periodically at affected employee training sessions and in employee publications. In addition, each affected employee shall receive a letter in the form of Attachment 1.4 summarizing this Program and identifying the Corporate Compliance Officer and the local compliance officer.

D. Specific Duties of the Corporate Compliance Officer.

The duties of the Corporate Compliance Officer shall include:

1. To know and understand all aspects of the Program;
2. To assure that all delegations of responsibility under the Program are made to persons reasonably believed to be honest and capable of making the judgments called for in the delegation;
3. To consult with Counsel to obtain interpretations of any requirements under the Program which are unclear, vague or which the Compliance Officer believes to be void, outdated or unworkable;

4. To bring to the attention of Counsel all changes in circumstances which could reasonably suggest that the Program should be modified;
5. To promptly carry out all duties expressly assigned to the Corporate Compliance Officer by the Program; and
6. To report periodically to the Board regarding the operation of the Program and relevant significant developments.

E. Training and Education

AH and its Affiliates shall develop an ethics training and continuing education plan for all affected employees. The requirements of this training and continuing education plan are:

1. Each local compliance officer, in consultation with the Corporate Compliance Officer, shall designate employees who are to attend training seminars.
2. Seminars for local compliance officers shall be conducted as needed, but at least annually, by the Corporate Compliance Officer and Counsel, who will discuss pertinent laws and regulatory developments. The Corporate Compliance Officer will retain the agenda for these seminars and attendance sign-in sheets. Counsel may participate in certain seminars by video-conference.
3. The Corporate Compliance Officer shall distribute any fraud alerts or similar notices issued by relevant government or professional entities to local compliance officers, who shall distribute them to all affected employees. Such employees shall be informed that they may obtain additional information regarding the pertinent laws and regulations from their local compliance officer.
4. The Corporate Compliance Officer shall disseminate alerts regarding new rules or regulations to each local compliance officer for further distribution to all affected employees and for inclusion in training manuals. The alerts shall be kept in a binder by the Corporate Compliance Officer at the AH corporate office and by each local compliance officer on site at each facility.
5. Each local compliance officer shall identify all affected employees with significant compliance responsibilities in their respective organization and provide appropriate training and education to these affected employees. The Corporate Compliance Officer, in conjunction with Counsel, may periodically create and disseminate training videos for this purpose.
6. The attendance of local compliance officers at training and educational sessions shall be documented by the Corporate Compliance Officer, and the attendance of other affected employees at training and educational sessions shall be documented by their respective local compliance officer. Those affected employees and compliance officers unable to attend general sessions shall be provided with follow-up training opportunities regarding the same subjects.

F. Documentation and Record Retention.

AH and its Affiliates shall establish a uniform filing and documentation system for documents described in this Program consistent with the following:

1. Local Documents. Each AH Affiliate that enters into an agreement subject to the Program shall maintain in its files:
 - (a) a copy of the signed agreement,
 - (b) any other business documents that affect the operations of the arrangement, and
 - (c) all exhibits to any such documents.

Except as necessary for its ongoing operations, AH Affiliates will not maintain a copy of any other document required by the Program.

2. AH Corporate Documents. The AH Corporate Compliance Officer shall maintain at the AH Corporate Office:
 - (a) a copy of all Board and the Board Compliance Committee (“BCC”) minutes authorizing each arrangement,
 - (b) a copy of the legal assessment received from Counsel regarding the arrangement; and
 - (c) All reports and complaints made to any compliance officer, including anonymous reports/complaints and written summaries of any oral complaints. Reports to management prepared as a result of complaints made to compliance officers shall also be filed in the compliance file.

All attorney-client privileged documents shall be filed separately from other documents and shall be maintained in a locked drawer.

3. Local and Corporate Documentation. Each compliance officer of AH and its Affiliates shall document and maintain files for their own organization with the following information:
 - (a) The dissemination of the Code of Conduct to employees, including the name of the employee, the date the employee was given the Code of Conduct, and a signed statement from employees who are required to affirm receipt of the Code of Conduct.
 - (b) The establishment and conduct of training sessions given to the local compliance officers and to affected employees. The documentation shall include the date of the training session, the presenter, the title of the

session and a brief description, a list of attendees, and a list of those absent who should receive materials regarding the session.

4. Legal Counsel Documents. Counsel shall maintain separate files, under its control, containing necessary documents regarding compliance matters. These files should include copies of documents required to be kept by Counsel under the Program.
5. Return or Disposal of Documents. Each AH Affiliate shall either return to Counsel or dispose of any documents not required to be maintained by the AH Affiliate under this Program.

G. Employee Reporting of Violations.

1. Employee Reporting and Report Forms. AH and its Affiliates shall inform their employees of their ability to send written reports to (or to otherwise contact) the Corporate Compliance Officer or their local compliance officer regarding any activity that the affected employee believes may be unlawful or an infraction of this Program. Affected employees shall also be informed that their report may be made anonymously, without fear of repercussion and, subject to law and the practicality of any investigation, confidentially.

AH organizations shall make available to affected employees a Compliance Program Report Form, in the form of Attachment 1.5 or 1.6 (“Report Form”). Local compliance officers and the Human Resources staff shall make Report Forms available to affected employees.

2. Protection of Employees. It is the policy of AH and its Affiliates that no employee shall be punished solely on the basis that he/she reported what he/she reasonably believed to be an act of wrongdoing or a violation of this Program.

However, an employee will be subject to disciplinary action if his/her employer reasonably concludes that the report of wrongdoing was knowingly fabricated by the employee or was knowingly distorted, exaggerated or minimized to either injure someone else or to protect or benefit the reporting employee.

3. Hotline. AH and AH Affiliates shall develop and inform their employees of the availability of a phone “hotline” for reporting suspicious conduct or violations of the Program. The hotline will be operated in a manner that assures proper investigation of reports and tracking of the results. The toll-free number is (888) 366-3833.
4. Exit Interview. All departing affected employees should submit to an exit interview.

One of the purposes of the exit interview is to determine if the affected employee has knowledge of any wrongdoing, unethical behavior or criminal conduct. The

interview also may be used to obtain information about unsafe, unsound or otherwise questionable business practices.

The interview should be conducted while the affected employee is still on the payroll and on the property of AH or an AH Affiliate. The interview should be conducted by someone other than the departing employee's immediate supervisor.

H. Tracking Employee Reports of Violations.

The recipient of a Report Form or any other documented report or complaint shall forward the report to the appropriate local compliance officer. Oral reports shall be memorialized in writing and forwarded. The local compliance officer shall immediately submit the report to the Corporate Compliance Officer. The Corporate Compliance Officer shall track all reports in the following manner:

1. Create a sequentially numbered tracking system for reports/complaints. Number and retain the oral or written employee complaint in the compliance file.
2. Request Counsel to prepare a report to the AH organization's President regarding the employee's concern.
3. Review the compliance file as appropriate to ensure that follow-up action has been taken on any outstanding employee complaints and concerns.
4. Incorporate any lessons learned into affected employee alerts, training or educational programs.

I. Auditing the Program

1. Conducting the Audit. Counsel shall conduct periodic audits of compliance with the Program by AH and AH Affiliates. This audit is intended to measure and improve the effectiveness of the Program. The audit shall focus on whether all arrangements involving AH or an AH Affiliate were entered into in compliance with this Program, and whether the parties' performance under each agreement conforms to the terms of the agreement. Audits shall be conducted as follows:
 - (a) Counsel and the Corporate Compliance Officer shall conduct periodic internal audits of each AH Affiliate to ensure that (i) the reporting system is implemented and properly functioning, (ii) employee reports and complaints have been tracked and addressed, (iii) any identified or suspected violation of the law has been rectified and the wrongdoer disciplined, as appropriate, and (iv) compliance issues identified in previous audits have been addressed in employee training programs or alerts and no longer occur.
 - (b) Counsel shall conduct periodic reimbursement audits targeting high-risk billing issues (e.g., home health, inpatient admissions, laboratory charges)

at all AH Affiliates. Audits shall be performed with external or internal audit resources under the direction of Counsel.

2. Reporting Non-Compliance. Any non-compliance with the Program by an AH Affiliate shall be reported to the Corporate Compliance Officer and corrected.
3. Audit Results. Results and lessons from both the Program audit and the reimbursement audit shall be incorporated in the training and education programs for compliance officers and other affected employees.

J. Enforcement and Discipline.

1. Policy. Known violations of the Program shall be treated at least as seriously as any other employment transgression, and may result in dismissal if such action is determined appropriate by the AH organization.
2. Standardized Disciplinary Guidelines. Disciplinary guidelines for intentional violations of the Code of Conduct shall be enforced consistently and uniformly by AH and AH Affiliates. AH and AH Affiliates shall make clear to their employees that the standards set forth in the Corporate Code of Conduct are important to the AH organization, and must be taken seriously by all employees. Violations of a standard will not be tolerated, and may result in the imposition of one or more of the following sanctions, as deemed appropriate by the AH organization:
 - (a) A warning;
 - (b) A reprimand (will be noted in individual's permanent personnel record);
 - (c) Probation;
 - (d) Demotion;
 - (e) Temporary suspension;
 - (f) Termination;
 - (g) Required reimbursement of losses or damages;
 - (h) Referral for criminal prosecution or civil action.

Determinations as to appropriate discipline will be made on a case-by-case basis. Sanctions imposed will reflect the seriousness of the offense and any unique circumstances of the situation. Any employee potentially subject to sanctions will be given notice, an explanation of the sanctions imposed, and a final review of his or her case by the AH President.

3. Employee Reviews. Each affected employee's annual personnel review shall include an assessment of the affected employee's known adherence to the Code of

Conduct. Conversely, a record of any discipline accorded to an affected employee as a result of noncompliance with the Code of Conduct shall be maintained, both in the compliance file and in the affected employee's personnel record.

K. Response to Suspected Violations of the Program.

In the event of a suspected violation of the Program, the local compliance officer shall be notified immediately.

The local compliance officer shall preliminarily verify the factual basis of a violation or suspected violation. If sufficient factual basis exists, the officer shall notify the President of the affected AH Affiliate, the Corporate Compliance Officer and Counsel. The local compliance officer, in consultation with such persons, shall decide on a response as soon as practicable. If there is any material factual basis or reasonable suspicion that a violation has occurred, the Corporate Compliance Officer shall perform the following:

1. Further investigation of any unknown or unanswered aspects of the alleged violation;
2. Prepare recommendations for corrective action;
3. Consult with Counsel regarding legal matters, such as the advisability of disclosing the incident to governmental entities; and
4. Formally notify the Board of Directors of the AH organization and the AH President of the incident and the planned response.

Six Attachments Follow

End of Part 1.

Attachment 1.1

YOUR RESPONSIBILITIES CORPORATE COMPLIANCE PROGRAM

This program provides a standard for ethical behavior and a reporting system for notifying management of potential ethical breaches. The organization's legal board adopted the formalized compliance program, which consists of written policies, procedures, and a code of conduct designed to prevent violations of applicable laws, regulations, policies and procedures. In addition it is designed to detect and correct violations, should they occur.

You may find the entire compliance program on Adventist Health's Roseville Connect Intranet page at: <https://connect.ah.org/portal/site/admin> under the Corporate Compliance Department "Compliance Program" folder or on Adventist Health's web page under "About Us:" <http://www.adventisthealth.com/aboutus/goDocDocument.asp?CN=3&DID=970> .

Adventist Health is a highly regarded healthcare provider. Our reputation has been achieved through the dedication of individuals committed to quality, honesty and fairness. Each of us is responsible for continuing to protect and enhance that reputation for the future. The Adventist Health Code of Conduct is based on the biblical counsel to treat others as we would have them treat us. Great effort is taken to ensure that as officers, employees, contractors or volunteers of Adventist Health and its affiliates, we conduct ourselves with integrity in accordance with all applicable laws and ethical business standards.

The material that follows is Adventist Health's formalized Code of Conduct, which in turn is followed by a brief description of the Federal and State laws addressing false claims and whistleblower protections.

ADVENTIST HEALTH CORPORATE CODE OF CONDUCT

Mission

Adventist Health's mission is to share God's love by providing physical, mental, and spiritual healing

Adventist Health ("AH") and its Affiliates, in keeping with their mission, strive to conduct themselves in accordance with strong business ethics and in compliance with all applicable laws. This Code of Conduct is upheld through the integrity and ethical practices of our officers, employees, contractors, and agents.

To maintain its standards in an increasingly regulated business environment, AH has established this formal Code of Conduct, which provides general guidelines on how AH and its Affiliates will conduct business. As such, this Code of Conduct governs the conduct of *all* employees and contractors of AH and its Affiliates. Knowledge of and adherence to these standards allows AH to continue serving its patients and communities in a professional, caring, and ethical manner.

Compliance with Laws

AH policy requires AH and its Affiliates, officers, directors, employees, contractors, and agents to comply with all applicable laws, including Federal and State health care program requirements. Failure to do so exposes AH organizations' officers, directors, employees, contractors, and agents to possible sanctions, monetary penalties, criminal prosecution and other disciplinary actions. When the application of a law is uncertain, AH or its Affiliates will seek appropriate guidance .

Reporting of Violations

AH and its Affiliates support and encourage any officer, director, employee, contractor, or agent to maintain individual responsibility for monitoring and reporting any activity that appears to violate any applicable laws, rules, regulations, policies and procedures, or this Code of Conduct. In order to provide every avenue possible in which to raise their concerns, AH and its Affiliates have established a confidential reporting mechanism that includes anonymous reporting if the person making the report so desires. Using this mechanism does not, however, relieve an individual of his other obligation to utilize the organization's grievance and arbitration procedures, if the matter is covered by such a procedure.

Anyone who becomes aware of a violation of any laws, including Federal and State health care program requirements, company policies and procedures, the AH Corporate Compliance Program, or this Code of Conduct is expected to report the improper conduct. This reporting can be accomplished either verbally or in writing through a supervisor, the local compliance officer, compliance report form, hotline, (888) 366-3833, or the AH Corporate Compliance Officer, (877) 336-3566. The local compliance officer, with assistance from the AH Corporate Compliance Department, will investigate all reports and ensure that proper follow-up actions are taken. AH policy prohibits any organization or individual from retaliating against a person who makes a complete and accurate report in good faith.

It is the policy of AH and its Affiliates that employees shall not be punished for reporting what they reasonably believed to be an act of wrongdoing or a violation of the AH Corporate Compliance Program.

However, an employee will be subject to disciplinary action if their employer reasonably concludes that the report of wrongdoing was knowingly fabricated by the employee or was knowingly distorted, exaggerated or minimized to either injure someone else or to protect or benefit the reporting employee.

Conflicts of Interest

AH and its Affiliates require officers, directors, employees, contractors, and agents to exercise individual loyalty to AH in fulfilling their responsibilities. These individuals must avoid any situation where a conflict of interest exists or might appear to exist between their personal interests and those of AH or its Affiliates. The *appearance* of a conflict may be as serious as an *actual* conflict of interest. If a conflict of interest exists or appears to exist, the individual must follow the conflict of interest procedures adopted by the AH organization, a copy of which is available.

Examples of Applicable Laws

Although it is not practical to list all laws, including Federal and State health care program requirements, to which AH and its Affiliates are subject, the following are examples of the more common laws subject to this Code of Conduct.

Patient Admission and Transfer

Admission to an AH facility should be based strictly upon medical necessity. Only an appropriately licensed person should determine whether to admit a patient to an AH facility. AH management should ensure that facility personnel and medical staff members are never pressured to admit patients inappropriately and that patients are admitted only on the basis of medical need.

A patient should not be transferred from an AH facility if such transfer threatens the patient's health or is in violation of law. If applicable, each AH facility shall adopt patient transfer protocols.

Payment for Referral

AH and its Affiliates do not offer, pay or receive payments in exchange for the referral of a patient or other business. AH and its Affiliates only pay people or entities for actual items or services provided to the organization or community. AH and its Affiliates do not offer or provide illegal benefits, whether cash or non-cash, to any physician or health professional.

Accuracy in Billing

AH and its Affiliates are committed to prepare and submit accurate claims for medically necessary services rendered. All bills must be accurate and conform with federal and state laws and regulations.

Marketing Activities

AH and its Affiliates must comply with all state and federal requirements regarding marketing.

Political Activities

Although officers, directors, employees, contractors, and agents are encouraged to participate freely and actively in the political process, they should ensure that their political activities are lawful and separate from their activities as an employee or contractor of AH or an Affiliate. Personal political activities must not unreasonably interfere with the individual's ability to perform his or her duties for the AH organization, and must be consistent with applicable laws, rules, regulations and the policies set forth in this Code of Conduct.

Patient Rights Laws

AH and its Affiliates are committed to abiding by all applicable laws, rules and regulations regarding and protecting their patients' rights, including confidentiality and other rights.

YOUR RESPONSIBILITIES

FEDERAL AND STATE FALSE CLAIMS ACTS

Federal and state false claims acts prohibit any person or entity from, among other things, knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval, or knowingly making or using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved.

The penalties for violating the federal or state false claims acts include:

- Civil monetary penalties of up to \$10,000 for each false claim submitted;
- Three times the amount of damages which the government sustains because of the false claim; and
- The costs of the legal action brought to recover for the false claim.

A private citizen may file suit under the federal and state false claims acts on behalf of the government if the citizen has direct and independent knowledge of the submission of a false claim. The government will then decide whether to intervene and take over the case, dismiss or settle the case, or let the private individual pursue the case on his or her own. In either case, the person who initially filed the case may receive a portion of the amount recovered in either litigation or settlement of the claim.

Your local compliance officer can provide more detailed information regarding the federal and state false claims acts.

YOUR RESPONSIBILITIES

WHISTLEBLOWER PROTECTIONS

Both the federal and state false claims acts prohibit employers from retaliating or discriminating against an employee who, acting in good faith, investigates, reports or assists in uncovering a false claim or statement.

An employee who suffers discrimination or retaliation based on protected activities has the right to sue under the both the federal and state false claims acts. If the employee can prove that his or her employer retaliated against him or her for engaging in protected activity, the employee is entitled to be “made whole.” The remedies may include:

- reinstatement of the employee to his or her position,
- two times the amount of back pay,
- interest on the back pay, and
- compensation for any special damages (including litigation costs and reasonable attorneys’ fees).

As noted above, it is the policy of Adventist Health and its affiliates that no employee shall be punished solely on the basis that he or she reported what he or she reasonably believed to be an act of wrongdoing or a violation of the Adventist Health Corporate Compliance Program.

YOUR LOCAL COMPLIANCE OFFICER CAN PROVIDE MORE DETAILED INFORMATION REGARDING THE PROTECTIONS AFFORDED EMPLOYEES UNDER THE FEDERAL AND STATE FALSE CLAIMS ACTS.

Attachment 1.2

**ADVENTIST HEALTH
CORPORATE CODE OF CONDUCT
ACKNOWLEDGEMENT OF RECEIPT AND REVIEW**

I have received and read a copy of the Adventist Health Corporate Code of Conduct and agree to abide by the policies and rules contained therein.

Adventist Health reserves the right to modify this Code at any time at its sole discretion.

Signature

Date

Attachment 1.3**Local Compliance Officer Contact Information**

Adventist Medical Center	Mike Davis No assistant	Phone: 503.257.2500 Email: DavisML@ah.org
Castle Medical Center	Dale Northrop Cindy Kilbey, Asst. Wendi Barber, Controller/ Compliance Coordinator	Phone: 808.263.5142 Email: NorthrDR@ah.org
Central Valley General Hospital	Kirby McKague Valerie Adams, Asst. Charles Ricks, Director of Contract Compliance	Phone: 559.585.5540 Email: MckaguKJ@ah.org
Feather River Hospital	Dan Gordon Loretta DePorceri, Asst. Shaunna Jones, Education & Training Manager	Phone: 530.877.9361 x8005 Email: GordonDK@ah.org
Glendale Adventist Medical Center	Kelly Turner Cyndy Avila, Asst. Claudia Kanne, Medical Staff Director/Contract Compliance	Phone: 818.409.8000 x8289 Email: TurnerKL@ah.org
Hanford Community Hospital	Kirby McKague Valerie Adams, Asst. Charles Ricks, Director of Contract Compliance	Phone: 559.585.5540 Email: MckaguKJ@ah.org
Howard Memorial Hospital	Carlton Jacobson Dona Fridae, Asst. x3047	Phone: 707.456.3001 Email: JacobsCE@ah.org
North Hawaii Community Hospital	Lexi Fields Susan Vuong, Asst. x4401 Leslie Ashimini, Asst. x4400	Phone: 808.881.4406 Email: FieldsLM@ah.org
Redbud Community Hospital	Buck McDonald Glenice Steck, Asst. Natalie Conant, Sr. Admin Asst.	Phone: 707.963.6217 Email: McdonaEA@ah.org
San Joaquin Community Hospital	Brent Soper Diane Chapman, Asst. 326.4147 Katherine Cody, Compliance Manager	Phone: 661.395.3000 Email: SoperWB@ah.org
Selma Community Hospital	Kirby McKague Valerie Adams, Asst. Charles Ricks, Director of Contract Compliance	Phone: 559.585.5540 Email: MckaguKJ@ah.org
Simi Valley Hospital	Clif Patten Jenee Potter x6208 Judi Olex, Compliance Manager	Phone: 805.955.6204 Email: pattencd@ah.org
Sonora Community Hospital	David Larsen Tracy Barnes, Asst.	Phone: 209.532.3161 x5011 Email: LarsenDL@ah.org
South Coast Medical Center	Wing Choi Joann Bishop, Asst.	Phone: 949.499.8626 Email: ChoiWW@ah.org
St. Helena Hospital	Buck McDonald Glenice Steck, Asst.	Phone: 707.963.6217 Email: McdonaEA@ah.org
Tillamook County General Hospital	Walt Larson Paula Morris, Asst. x2260	Phone: 503.815.2263 Email: LarsonWA@ah.org
Ukiah Valley Medical Center	Cheryl Curry Kitty Sanders, Asst. 463.7692	Phone: 707.463.7555 x1604 Email: CurryCL@ah.org
Walla Walla General Hospital	Duane Meidinger Peggy Morrison, Asst.	Phone: 509.527.8000 x1000 Email: MeidinDA@ah.org
White Memorial Medical Center	John Raffoul Cecilia Alfaro, Asst. Steven Stubbs, Compliance Contract Manager	Phone: 323.260.5847 Email: RaffouJG@wmmcpo.ah.org

Attachment 1.4

ADVENTIST HEALTH CORPORATE CODE OF CONDUCT

EMPLOYEE ALERT

Dear Employee:

Adventist Health and its health care facilities and Affiliates (“AH”) have a long history of serving patients and the community. As we work on behalf of our patients, we do so knowing that we also have a long tradition of maintaining good business practices, upholding ethical business standards, and complying with the laws that govern our corporate activities.

AH has adopted a Corporate Code of Conduct as part of its Corporate Compliance Program (the “Program”). The Code of Conduct is being distributed to each employee as a reminder that we all have an obligation to maintain ethical and legal business behavior. This employee alert is being distributed to address some questions and answers that will help clarify the components of our program.

Why do we need the Corporate Code of Conduct and Corporate Compliance Program?

Today’s business environment is complicated. The Program provides a mechanism and a process for complying with the specific statutes and regulations that govern our business. In addition, the Program will help us live up to and maintain our ethical standards.

What does the Program really mean?

It means that each of us is expected to be aware of good business and ethical standards and accept responsibility for upholding them. It also means adhering to applicable laws and regulations that affect our business, and behaving ethically toward each other and our patients.

More specifically, what does the Program involve?

The Program monitors the activities of AH organizations, including what we do and how we accomplish our objectives. The goals of the Program are to resolve problems internally and to prevent problems from developing. The Program requires employees to comply with, and report any suspected violations of laws, rules, regulations or the Corporate Code of Conduct. Your local compliance officer and/or the Corporate Compliance Officer should be contacted regarding any suspected violations -- and such contacts may be made anonymously. The Program also requires certain arrangements to be reviewed by legal counsel and be approved by the Board, or its Designee, prior to implementation.

Who is your local compliance officer?

_____ is your local compliance officer, who may be contacted at _____. Doug Rebok is the Corporate Compliance Officer responsible for the entire Program. He may be contacted at (916) 781-4730.

What is appropriate for reporting to a compliance officer?

Any event or circumstance that:

- you believe violates corporate policy;
- you feel violates a law, rule or regulation;
- you believe is unethical; or
- you believe is not in keeping with AH's standards.

Some instances are clear-cut violations, while others may be a judgment call on your part.

What is inappropriate to report to compliance officers?

It is the policy of AH and its Affiliates that no employee shall be punished solely on the basis that he/she reported what he/she reasonably believed to be an act of wrongdoing or a violation of this Program.

However, an employee will be subject to disciplinary action if his/her employer reasonably concludes that the report of wrongdoing was knowingly fabricated by the employee or was knowingly distorted, exaggerated or minimized to either injure someone else or to protect or benefit the reporting employee. Using this mechanism does not, however, relieve an employee of his/her obligation to timely utilize the organization's grievance and arbitration procedures, if the matter is covered by a procedure.

How do I report a concern to a compliance officer?

You may complete a compliance program reporting form and return it to one of the following people: your supervisor, a corporate officer, your local compliance officer, or the Corporate Compliance Officer, with whomever you are most comfortable communicating. In addition, AH established a toll-free phone hotline for reporting violations. That phone number is (888) 366-3833.

What happens after a situation is reported?

The situation is investigated as thoroughly as possible. If further information is needed and the person who reported the situation provides his or her name, there will be follow-up with that person. All reports will be reviewed and investigated. If appropriate, a report will be made to the organization's Board of Directors.

Where do I find the compliance program reporting form?

The forms are available from the AH organization's human resources representative, from the Corporate Compliance Officer, or from a local compliance officer.

What happens if the report concerns a high-level employee?

All reports will be reviewed and investigated, regardless of the department involved or the level of the employee.

Will my name remain confidential?

You may make reports anonymously, but providing your name may prove helpful if further information is needed to proceed with the investigation. Careful efforts will be made to handle investigations with the utmost confidentiality, subject to the procedures of this Program and legal requirements. If a governmental or other outside party becomes involved, it may be necessary to give your name to that party.

Will the employee reporting a suspected violation be informed of the outcome of the investigation?

We can inform a person who files a report whether the matter has been investigated and the appropriate steps have been taken, but we cannot reveal confidential information regarding any employee. If someone is reprimanded or otherwise disciplined as a result of a report and the resulting investigation, that person may be entitled to privacy under labor and other laws.

End of Attachment 1.4, Part 1

Adventist Health
Corporate Compliance Program
Part 2: Contract And Approval Guidelines for Referral Source Arrangements
Checklist

Actions relating to the Compliance Program Specifically:

- _____ All employees involved in negotiating and processing referral source arrangements must receive a copy of the AH Compliance Program, Part 2.

Actions required by the Compliance Program Concerning Operations:

Approval Guidelines:

- _____ Management should discuss the proposed contract structure and terms with the Governing Board Chairperson and Local Compliance Officer
- _____ Risk Management should review the referral source contract if the indemnity provisions are modified and all agreements that are not derived from the compliance program manual or are outside the scope of the referral source contract program.
- _____ See referral source table for the appropriate approval body (Legal Board, BCC, CEO).
- _____ Legal counsel shall be involved in all arrangements that 1) materially deviate from the model documents; 2) guidelines recommend legal involvement; and 3) arrangements drafted by attorneys not associated with Latham & Watkins.

Approval Process:

- _____ Management should notify L&W when the arrangement appears likely to proceed.
- _____ Request L&W to prepare a legal opinion when the arrangement is in final form.
- _____ Create a “Transaction Summary” in ComplianceNet.
- _____ Send L&W all final documents and relevant supporting documents at least 21 days prior to asking the Legal Board or BCC for final approval.
- _____ L&W sends AH Compliance Dept the Transaction Summary and Legal Risk Memo 5 business days prior to scheduled BCC date.
- _____ Legal Board or BCC reviews the transaction and approves or rejects it.
- _____ AH Corporate Compliance Department faxes out approval confirmation forms following final approval.

After Approval:

- _____ Execute the final agreement after Legal Board/BCC approval.
- _____ Send copies of executed agreements and supporting documentation to the L&W.
- _____ Maintain a filing system that contains 1) the final executed agreement; 2) all necessary supporting documents; and 3) Transaction Summary.
- _____ Discard the L&W legal risk memo. Both L&W and AH Corporate Offices keep copies the risk memos.

Interim Letter Agreements; Retroactive and Ratified Agreements:

- _____ Interim letter agreements (ILA) (an arrangement intended to cover services or payments prior to the signing of a definitive agreement that is approved by BCC) are to be used infrequently.
- _____ Retroactive and ratified arrangements must be reviewed by the appropriate approval body.

**PRIVILEGED AND CONFIDENTIAL
ATTORNEY CLIENT COMMUNICATION
ATTORNEY WORK PRODUCT**

Adopted: September 22, 1997

**ADVENTIST HEALTH
Corporate Compliance Program**

PART 2: Contract and Approval Guidelines for Referral Source Arrangements

A. Introduction.

Federal and state laws prohibit health care providers from paying for the referral of patients or other business. This Part 2 of the Compliance Program (“Program”) establishes AH’s policies and procedures regarding compliance with laws governing financial relationships and referrals between AH Affiliates and physicians or other sources of patient referrals or other business.

Under certain laws, the acts of an employee might be attributed to AH and/or its Affiliates. Thus, it is imperative that employees involved in arrangements affected by federal and state laws governing provider relationships be familiar with those laws. Such familiarity will be an essential part of each employee’s job performance and a regular part of the employee’s review.

Part 2 of the Program is intended to prevent AH Affiliates from paying any form of unlawful remuneration to any potential referral source. This Part of the Program sets forth: “Contract Guidelines” for developing certain contracts with referral sources, and “Approval Guidelines” for obtaining approval of arrangements subject to this Part 2. Part 2 is intended to ensure that the employees and independent contractors of AH and its Affiliates (collectively referred to as “employees”) do not violate anti-referral or tax-exemption laws.

When an AH Affiliate develops an arrangement with a referral source that is subject to this Part 2, it must:

1. document the arrangement pursuant to the Contract Guidelines in ComplianceNet (referred to as “Transaction Guidelines” in ComplianceNet), and
2. obtain approval of the arrangements pursuant to the Approval Guidelines set forth below.

B. When to Use the Contract and Approval Guidelines.

An AH Affiliate must comply with both the Contract Guidelines and the Approval Guidelines before it:

- enters into any agreement, settlement or other arrangement with, or makes any payment to,
- any physician, other person or entity (such as a medical group)¹
- that refers or may refer, a patient to the AH Affiliate, or otherwise arranges business for the AH Affiliate.

Arrangements subject to this Part 2 include:

1. Any contract or understanding between an AH Affiliate and a physician or medical group that refers patients to an AH Affiliate, including arrangements with physician owned IPAs and any physician owned managed care arrangement.
2. Any contract or arrangement between an AH Affiliate and any referral source who arranges any business for the AH Affiliates.
3. Any contract or arrangement between one AH Affiliate and another AH Affiliate if there are patient referrals between them and the payment flows through the AH Affiliate to a referral source (e.g., a physician).
4. Contracts or other arrangements between a medical foundation and an affiliated or subcontracting medical group.

C. When Part 2 Does Not Apply.

Relationships not subject to the Contract Guidelines and Approval Guidelines of this Part 2 include:

1. Arrangements with a physician, person or entity that receives patients or business from an Adventist Health Affiliate. Note, however, that Part 3 or 4 of the Program might apply to that arrangement. Also note that these arrangements may present legal risk, and legal counsel should be consulted.
2. Any contract or arrangement between one AH Affiliate and another AH Affiliate if:
 - (a) there are no patient referrals between them, or

¹ These Guidelines refer to such a physician, person or entity as a “referral source.”

- (b) there is no payment or other benefit from the arrangement that flows through an AH Affiliate to a referral source (e.g., the payment does not go to a physician).
- 3. Agreements between individual physicians and medical groups that subcontract or are affiliated with an AH Affiliate.
- 4. Contracts between AH home health agencies and an AH Affiliate, provided that the guidelines in this Program for home health agencies are followed.
- 5. Payor contracts between an AH Affiliate and a payor. Note, however, that legal risks may arise from these arrangements, and legal counsel should be consulted.
- 6. Case rate and other managed care contracts. (As noted above, arrangements with physician owned IPAs are subject to the approval process.)

D. Contract Guidelines.

Legal counsel (“Counsel”) has been retained to assist AH and its Affiliates in developing relationships with referral sources. AH, in consultation with Counsel, has developed model agreements and Contract Guidelines (i.e., guidelines for completing the model agreements) for the following provider-physician transactions:

Document Name

- 1. Administrative Services Agreement
- 2. Emergency Call Coverage Agreement
- 3. Emergency Department Services Agreement
- 4. Equipment Lease Agreement
- 5. Home Health Agency Medical Directorship Agreement
- 6. Hospice Medical Directorship Agreement
- 7. Line of Credit and Security Agreement
- 8. Loan and Security Agreement
- 9. Management Services Agreement
- 10. Medical Directorship Agreement
- 11. Medical Office Lease Agreement (favors Landlord)
- 12. Medical Office Lease Agreement (favors Tenant)
- 13. Medical Office Lease Guaranty
- 14. Medical Practice Asset Purchase Agreement
- 15. Physician Employment Agreement

16. Practitioner Recruitment Agreement (Solo)
17. Practitioner Recruitment Agreement (Group)
18. Professional Services Agreement (Solo)
19. Professional Services Agreement (Group)
20. Teaching Services Agreement (Solo)
21. Teaching Services Agreement (Group)

These model agreements and Contract Guidelines are maintained and accessible via the internet on Latham & Watkins ComplianceNet program at <http://www.hc.lw.com>. AH Affiliates shall strive to materially comply with these Contract Guidelines and use the model contracts, except as otherwise allowed by the person(s) responsible for final approval.

E. Approval Guidelines.

Any proposed arrangement subject to this Part 2 must comply with two stages prior to an AH Affiliate executing an agreement or making any payment under the arrangement. The stages are: (1) preparation for approval and (2) final approval.

1. Preparation for Approval.

- (a) **Management Review.** Before presenting a proposed arrangement for final approval, management should discuss the structure, financial terms, risks and potential conflicts of interest of the arrangement with the Governing Board Chairman and the local compliance officer.
- (b) **Risk Management.** If the documents are generated from the compliance program manual, AH corporate's risk management department does not need to review the agreement unless: the indemnity provisions are modified, or the insurance provisions are modified. If documents are not derived from the compliance program manual (either because there is no model or because the transaction is outside the scope of the compliance program), the risk management department should review the documents.
- (c) **Legal Counsel Involvement.** Latham & Watkins should be significantly involved in:
 - (i) The development of all arrangements that materially deviate from the model documents or Contract Guidelines (Transaction Guidelines) set forth in ComplianceNet;
 - (ii) Transactions where the Contract Guidelines recommend attorney involvement (e.g., medical practice acquisitions); and
 - (iii) All agreements drafted by attorneys other than Latham & Watkins. In addition, Latham & Watkins should be consulted during other

contract negotiations to ensure compliance with laws governed by this Part 2.

- (d) **Preparation of Legal Memo.** Latham & Watkins must provide to the Corporate Compliance Officer a “legal memo” identifying specified legal risks of each proposed arrangement. Attachment 2.1 sets forth the format and identifies the laws addressed by the legal memo.

If legal counsel assesses the legal risk to be other than “low” (as defined below), the legal memo should provide an analysis of the applicable law and an explanation of why the risk exceeds low. The terms used in the memos shall have the following meanings:

- (i) **Low:** after considering the ambiguity or uncertainty of how the law, regulations and/or governmental enforcement position would apply to the proposed arrangement, as well as the strengths and weaknesses of the arguments supporting the legality of the arrangement, Latham & Watkins believes that the structure of the arrangement satisfies the regulatory statutes as defined and established in the Safe Harbor criteria, or it is more likely than not that the arguments supporting the particular arrangement will ultimately prevail if the arrangement is challenged and pursued to the full extent of the law. This assessment assumes that all factual issues (which are the responsibility of management) are resolved in a manner consistent with the law, and that all assumptions are current. The conclusion focuses solely upon the legality of the structure of the arrangement. Typically, this risk assessment is given to an arrangement when the law is relatively clear and/or governmental enforcement agencies have provided guidance as to their interpretation of the law, and the proposed arrangement appears to meet the law and those guidelines with respect to all material issues. Nonetheless, the proposed arrangement may still present some legal risk because of uncertainty arising from factual issues, opposing legal arguments that could prevail in court, uncertainty regarding governmental enforcement policy, and other variables.
- (ii) **Above Low:** after considering the same considerations as “low” above, Latham & Watkins believes that there is more likelihood of the arrangement being successfully challenged than a “low” risk assessment and that the client should be aware of this increased risk. Often, this risk assessment arises due to variables such as informal pronouncements by governmental enforcement agencies questioning arrangements similar to the proposed arrangement (and thereby serving notice that governmental agencies may choose to challenge the arrangement), a technical reading of a particular statute or regulation where it is not clear whether the

proposed arrangement materially deviates from the statute or regulation, or other factors that indicate an increased likelihood of challenge and possibility of adverse outcome with respect to the arrangement. This risk assessment could include arrangements where Latham & Watkins believes that there are reasonable and viable arguments against the proposed arrangement, and it is not clear what result a court would come to if presented with the arrangement. If possible, Counsel will identify in the memo the level of legal risk, including descriptions of whether the risk is uncertain, more likely than not, etc.).

- (iii) Latham & Watkins may also develop and maintain an internal memo, for Latham & Watkins' own files, memorializing the rationale for the legal memo. If management prefers to review a copy of the internal memo, management may request it from a Latham & Watkins attorney, but must return the memo to Latham & Watkins after such review. Additionally, management may review legal treatises summarizing Latham & Watkins' application of certain federal and state laws and regulations. These legal treatises are available on ComplianceNet (under the link "Legal Authority").

(e) **How to Obtain a Legal Memo.** The following procedures apply to all legal memos:

- (i) Management should inform a Latham & Watkins attorney of a possible transaction as soon as it appears likely that the transaction will proceed, and coordinate the timing of receiving a legal memo.
- (ii) Management should request a legal memo from a Latham & Watkins attorney as soon as management believes the arrangement has reached its final structure.
- (iii) Management should submit a "transaction summary" to Latham & Watkins. Most transaction summaries may be created and submitted ("posted") by entering the appropriate data into ComplianceNet's web page template. Management should send a hard copy of the transaction summary via e-mail, facsimile, ground mail, or express mail only when a ComplianceNet template does not exist or management does not have access to the internet application. That memo should summarize the terms of the proposed transaction and identify how the arrangement deviates from the Compliance Manual. Any deviations from the model documents should be redlined or otherwise highlighted.
- (iv) As soon as the final documents are ready, management should send copies to the Latham & Watkins attorney, along with all other

materials that will be presented for final approval. Practically, Latham & Watkins should receive documents as early as possible - the more time given for review, the more time there is to resolve any last-minute problems that might exist.

- (v) Latham & Watkins must receive all final materials twenty-one (21) business days or more prior to the date on which documents will be submitted for final approval, but management should send documents to Latham & Watkins as soon as possible if the documents are ready earlier. If the time requirements are not met, final approval will be delayed until a subsequent date. (Please refer to the Board Compliance Committee's Compliance Calendar, available on ComplianceNet, to review submission deadlines.)
- (vi) Management should discuss the contents and rationale for each conclusion in a legal memo with Latham & Watkins prior to the memo being finalized.
- (vii) The Latham & Watkins attorney will send a legal memo to the Corporate Compliance Officer or the Director of Corporate Compliance ten (10) business days after receiving all final materials from management.

- (f) **Adventist Health's Risk Management.** Review by Adventist Health risk management is only necessary if:
 - (i) the parties intend to modify the insurance or indemnity provisions of any Compliance Manual model agreement;
 - (ii) a physician or other third-party will receive insurance or other risk management services from an AH organization; or
 - (iii) the parties have developed an agreement not based on a model agreement.

- 2. **Final Approval.** Attachment 2.2 is a chart that identifies who must approve each type of arrangement that is subject to this Part 2 of the Program.

To obtain final approval, management must present the following to the AH Corporate Compliance Officer at least five (5) business days prior to final approval:

- (a) **Transaction Summary.** The transaction summary should include the purpose, structure, financial terms, and the business and financial risks of the arrangement. The transaction summary must also provide a clear explanation of the community benefit derived from the arrangement. Attachment 2.3 contains transaction summary samples from ComplianceNet. Management should create and submit ("post") its

transaction summaries for various types of arrangements (recruitment, services agreement, etc.) using ComplianceNet.

- (b) **Legal Memo.** The legal memo indicating the legal risks of the arrangement must be presented or orally summarized to person(s) approving the arrangement.
- (c) **Agreement and Supporting Documentation.** The arrangement should not be presented for final approval until the agreement, exhibits and any supporting documentation required by the Compliance Manual (e.g., appraisals, reasonable compensation opinions, documentation supporting rental rates, etc.) have been completed in a manner consistent with the model agreements and their guidelines. Final approval may, however, be given subject to a final valuation if a preliminary valuation has established a price range and the Legal Board or Board Compliance Committee (“BCC”) authorizes management to approve a final price that is within that range.
- (d) **Conflicts Findings.** If a conflict of interest exists, management should present any information and materials that are necessary to assist the Legal Board in making the findings required by the Adventist Health Conflicts of Interest Policy.
- (e) The Corporate Compliance Officer will then present the appropriate materials to the person(s) responsible for final approval.

F. After Final Approval.

- 1. **Execution of Documents.** Documents pertaining to an arrangement should not be executed until the arrangement has received appropriate final approval.
- 2. **File Copies and Supporting Documentation.** A copy of all executed agreements and supporting documents must be sent to the paralegal in charge (“primary paralegal”) of the Adventist Health facility. The primary paralegal is identified on the “Risk Assessment Distribution Chart” and the “Facility Compliance Program Information Chart” (available on ComplianceNet under the link “Compliance Officers”). The primary paralegal will follow-up with management or the appropriate local compliance officer to ensure that all documentation is completed in accordance with the Program.

G. Interim Letter Agreements; Retroactive and Ratified Agreements.

- 1. If the parties know that an interim arrangement (i.e., an arrangement that is intended to cover services or payments occurring prior to the parties signing a definitive agreement that has been approved by the BCC) will be necessary, and the Governing Board Chairman of an AH Affiliate has approved the interim arrangement, the parties should sign an Interim Letter Agreement (“Letter Agreement”) (a model is attached as Attachment 2.4 and is also available on

ComplianceNet under the link “Supporting Documents”), with financial terms that have been approved by the Governing Board Chairman, prior to the referral source providing any services for which any payment will be made. The Letter Agreement provides that the organization’s obligation to make payments is subject to final approval. A definitive agreement should then be developed and approved pursuant to this Part 2. The definitive agreement supersedes the Letter Agreement (and the terms of the definitive agreement are effective as of the date of the Letter Agreement).

2. All other interim arrangements and retroactive agreements should be proposed to the Board for review, comment, and possible approval.
3. If the parties have executed an agreement prior to review and approval pursuant to this Part 2, management shall submit the agreement for ratification to the appropriate approval body, and follow that body’s instruction.

Four Attachments Follow

End of Part 2.

Attachment 2.1

MODEL LEGAL MEMO

[Available Upon Request from AH Compliance Program]

Attachment 2.2**FINAL APPROVAL OF
REFERRAL SOURCE ARRANGEMENTS**

TRANSACTION	Final Approval Must Be Obtained From:		
	LEGAL BOARD	BOARD COMPLIANCE COMMITTEE	CEO
Medical Director Services	Annual compensation is more than \$300,000 per FTE physician, <u>or</u> the term is over five years.	Annual compensation is \$300,000 or less per FTE physician <u>and</u> term is five years or less.	N/A
Administrative Services	Annual FTE compensation is \$300,000 or more, <u>or</u> the term is over five years	Annual FTE compensation is less than \$300,000 <u>and</u> term is five years or less.	N/A
Hospital Based Services	Annual FTE compensation is \$300,000 or more, <u>or</u> the term is over five years.	Annual FTE compensation is less than \$300,000 <u>and</u> term is five years or less.	N/A
Teaching Agreements	Annual FTE compensation is \$300,000 or more, <u>or</u> the term is over five years.	Annual FTE compensation is less than \$300,000 <u>and</u> term is five years or less.	N/A
Loans (or Lines of Credit) to Physicians	The loan amount is \$200,000 or more, <u>or</u> the repayment schedule exceeds five years	The loan amount is less than \$200,000 <u>and</u> the repayment schedule is five years or less.	N/A
Equipment Lease	Lease payments are more than \$200,000 per year, <u>or</u> the term of the lease exceeds five years.	Lease payments are \$200,000 or less per year, <u>and</u> the term of the lease is five years or less.	N/A

	Final Approval Must Be Obtained From:		
TRANSACTION	LEGAL BOARD	BOARD COMPLIANCE COMMITTEE	CEO
New Office Lease	Lease payments are more than \$200,000 per year, <u>or</u> the term of the lease exceeds five years.	Lease payments are \$200,000 or less per year, <u>and</u> the term of the lease is five years or less.	N/A
New Office Lease/If Independent Management Company Controls Lease Documents	N/A	All other agreements.	The management company must (1) negotiate the lease without management involvement, (2) have a financial incentive to maintain commercially reasonable office leases, and (3) use the Compliance Manual model lease. ¹
Ground or Land Lease	All leases.	N/A	N/A
Renewal of Office Lease	N/A	All renewals.	N/A
Extension of the term of an existing agreement (not including office lease agreements)	The agreement goes through the approval process applicable to that type of transaction. The Compliance Manual should be used.		
Amendments to Existing, Signed Agreements	All amendments deemed material by the CEO, or changes to financial terms, or amendments made three years or more into the term of the agreement.	All immaterial and non-financial changes made within first three years of the agreement.	
Emergency Room Call Coverage	All coverage programs that cost, or could cost, more than \$300,000 per year (per specialty).	All coverage programs that cost, or could cost, \$300,000 or less per year (per specialty).	N/A

TRANSACTION	Final Approval Must Be Obtained From:		
	LEGAL BOARD	BOARD COMPLIANCE COMMITTEE	CEO
Recruitment	All other recruitment packages.	The total potential value of all recruitment incentives is \$450,000 or less in any given year <u>and</u> any income guarantee is for two years or less.	N/A
Turnkey Management Services Agreement	N/A	All MSO arrangements.	N/A
Simple Billing, Collection or Other Support Services	N/A	All agreements.	N/A
Purchase of Physician Practice	All other practice purchases.	Purchase of only tangible assets, with an independent valuation establishing the FMV of the assets as less than \$100,000 per physician.	N/A
Locum Tenens	N/A	N/A	All agreements. ²
Residency Agreements	N/A	N/A	All agreements. ³
Transfer Agreements where no compensation is required	N/A	N/A	All agreements
Medical Staff Officer Stipends	N/A	Compensation exceeds \$36,000 per year.	Compensation is \$36,000 or less per year. ³
Physician-Hospital Meeting Agreements	N/A	N/A	All agreements. ⁴

TRANSACTION	Final Approval Must Be Obtained From:		
	LEGAL BOARD	BOARD COMPLIANCE COMMITTEE	CEO
Any other Contract or Arrangement with a Physician or Referral Source Subject to Part 2.	N/A	All agreements.	N/A
Agreements with aggregate compensation less than or equal to \$150 per month or less than or equal to \$1,800 per year.	N/A	N/A	All agreements. ⁵

¹ The CEO may approve leases if (i) the organization has delegated its authority to negotiate office space leases to an independent management company without management involvement or direction, (ii) the management company has a financial incentive to maintain commercially reasonable offices leases (e.g., the management company is paid a percentage of the office lease rental), and (iii) the management company uses the Compliance Manual’s then-current model lease document.

² A locum tenens arrangement is one in which the hospital contracts with a third-party, independent company (and makes all payments to that company for physician services to be provided in the community to fill a community need. Any arrangement that is not with an independent third-party company should be treated as a direct arrangement with a physician, and should be subject to the BCC-Board review process.

³ Unusual situations should be reviewed by legal counsel.

⁴ If the model agreement in the form substantially adopted by AH is not used, the proposed arrangement must be reviewed and approved by the Board Compliance Committee.

⁵ Agreement must adhere to all other requirements of the “Contract and Approval Guidelines for Referral Source Arrangements.”

Attachment 2.3

SAMPLES OF TRANSACTION SUMMARIES

[Redacted: Pages 43 – 50]

[Available Upon Request from AH Compliance Dept.]

Attachment 2.3 (Continued)

SAMPLE OF TRANSACTION SUMMARY

**[Administrative Services Agreement, Emergency Call
Coverage Agreement, Medical Directorship Agreement,
or Professional Services Agreement]**

Redacted: Page 44-45

[Available Upon Request from AH Compliance Dept.]

Attachment 2.3 (Continued)

SAMPLE OF TRANSACTION SUMMARY

[Medical Office Lease]

Redacted: Page 46

[Available Upon Request from AH Compliance Dept.]

Attachment 2.3 (Continued)

SAMPLE OF TRANSACTION SUMMARY

[Practitioner Recruitment Agreement]

Redacted: Page 47-48

[Available Upon Request from AH Compliance Dept.]

Attachment 2.3 (Continued)

SAMPLE OF TRANSACTION SUMMARY

[Loan/Line of Credit Agreement]

Redacted: Page 49

[Available Upon Request from AH Compliance Dept.]

Attachment 2.3 (Continued)

SAMPLE OF TRANSACTION SUMMARY

[Equipment Lease Agreement]

Redacted: Page 50

[Available Upon Request from AH Compliance Dept.]

Attachment 2.4

MODEL INTERIM LETTER AGREEMENT

[Redacted: Pages 51-53]

[Available Upon Request from AH Compliance Dept.]

Adventist Health
Corporate Compliance Program
Part 3: Home Health & Hospice
Checklist

Actions relating to the Compliance Program Specifically:

- Review the compliance program with Home Health Agency staff annually.
- Distribute the notice entitled, “A Personal Commitment to Integrity” to each employee.
- Obtain signed “Acknowledgement of Receipt and Review” from each employee.
- Post the “Reporting Compliance Concerns” in a location each employee can view periodically.
- Have the “Compliance Report” form available where employees can pick it up anonymously. These should be available so that employees can use them to report compliance concerns.

Actions required by the Compliance Program Concerning Operations:

Standards of Conduct:

- Requires each employee to report fraud, waste, abuse, and/or unethical activity.
- Staff provide medically necessary services

General Policies & Procedures

- Adhere to state and federal licensing requirements & Medicare conditions of participation.
- Notify the State licensing of any change in: a) ownership, b) officers, directors, agents, or managing control interest in the agency; and c) corporation, association, or company responsible for agency.
- The agency will not discriminate against patients
- Inform patients of termination of services when additional services are necessary.

Billing

- Submitted claims accurately reflect the services provided.
- Bill Medicare only for services provided to Medicare eligible patients
- Medicare is billed for services that are 1) medically necessary, 2) provided to eligible patients, and 3) qualify as covered services.
- Medicare is only billed for services that have been certified by the attending physician.
- Agency must inform each physician who signs a “certificate of need” of Medicare’s limitations regarding certification.
- Care plans and other physician orders must be signed and dated by the attending physician before claims for those services are submitted to the Medicare program.
- CPT & HCPCS codes must accurately describe the services ordered and performed.
- Only diagnostic information obtained from the attending physician must be used when billing and in accordance with guidelines set forth in the compliance program.

Adventist Health
Corporate Compliance Program
Part 3: Home Health & Hospice
Checklist

_____ Agency personnel should periodically verify claims are supported by appropriate documentation.

_____ Only submit claims for services both ordered and performed. Written or verbal orders must be obtained from the attending physician prior to providing the services.

_____ The agency must establish and maintain a process that ensures the claims accurately represent medically necessary services provided and supported in conformity with state and federal regulations.

Financial Arrangements with Referring Physicians

_____ Financial arrangements with referring physicians must comply with the Referral Source Compliance Program

Financial Arrangements with Providers and Suppliers

_____ Agreements must be in writing and consistent with the principles of the AH Compliance Program.

OIG Fraud Alerts

_____ Each AH Agency must comply with the OIG Fraud Alerts that are periodically published on the OIG web site.

Prohibited Compensation Arrangements with Billing Staff and Consultants

_____ Compensation must not be in a method that encourages erroneous submission of claims.

Marketing

_____ The agency must ensure that all marketing is honest, straightforward, informative, and non-deceptive and that staff and contracted agencies are properly trained concerning marketing activities.

Credit Balances

_____ Agency must promptly refund/provide credit balances.

Cost Report

_____ The cost report must accurately represent allowable costs in conformity with government regulations and not constitute duplicate reimbursement.

Training and Education

_____ All employees shall receive compliance training as appropriate to their responsibilities.

Record Retention

_____ The agency shall conform to the AH record retention policies.

Anti-kickback Statutes

_____ Agency shall not pay for referrals.

State Laws

_____ Agency shall comply with all state licensing laws.

**PRIVILEGED AND CONFIDENTIAL
ATTORNEY-CLIENT COMMUNICATION
ATTORNEY WORK PRODUCT**

May 21, 1999

**ADVENTIST HEALTH
Corporate Compliance Program**

PART 3: HOME HEALTH AGENCIES AND HOSPICE PROGRAMS

I.

INTRODUCTION

Adventist Health (“AH”) has established the following policies and procedures for home health agencies and hospice programs in its efforts to ensure compliance with applicable state and federal laws.

This Part 3 of the Compliance Program establishes AH’s policies and procedures regarding compliance with laws specific to home health agencies and hospice programs. These policies and procedures are intended to assure that AH home health agencies and hospice programs and their agents and employees comply with applicable laws, regulations, manual provisions and other government pronouncements that relate to home health agencies and hospice programs.

While these policies and procedures highlight federal and state laws specific to home health agencies and hospice programs, they do not include every legal requirement that applies to home health agencies and hospice programs. Thus, each AH organization must ensure that its home health agency and/or hospice program is in compliance with all laws, regulations and other applicable federal and state government pronouncements.

II.

INTENT

The following policies and procedures are a component of the Compliance Program. These policies and procedures reflect AH’s strong commitment to comply with all laws and regulations affecting its home health agency and hospice program operations.

Each AH home health agency and hospice program will receive a copy of these policies and procedures. In addition, a training and education program will help ensure that employees understand the standards of conduct that they are expected to follow.

These policies and procedures are designed to *prevent* violations of applicable laws, regulations, policies and ethical requirements by helping employees choose the proper course of action when faced with difficult compliance issues. Specifically, these policies and procedures encourage

employees to seek advice whenever they are uncertain as to the proper course of action. The employee's supervisor, local director, local compliance officer, and AH's Corporate Compliance Officer are always available to help answer any questions an employee may have concerning compliance issues.

These policies and procedures are also designed to *detect and correct* violations of applicable laws, regulations, policies and ethical requirements. Therefore, it is the duty and responsibility of each employee to report promptly any violation or potential violation of these standards to the appropriate person.

III.

POLICIES AND PROCEDURES FOR HOME HEALTH AGENCIES

A. Introduction

1. Standards of Conduct

AH does not tolerate fraud and abuse by its agents or employees. Accordingly, it is AH's express intention that each and every home health agency employee prevent, discourage, and/or halt any such fraud, waste, and abuse or unethical activity discovered. Any activity that violates this policy must be reported immediately to the facility compliance officer assigned to that home health agency.¹

Moreover, AH encourages and expects full adherence to all guidelines and regulations governing federally funded health care programs, as distributed from time to time by the home health agency's fiscal intermediary/carrier or other government agency (e.g., new billing procedures, fraud alerts, etc.).

2. General Policies and Procedures

Each AH home health agency should ensure that the services it provides are neither: (1) greater than what is medically necessary (over-utilization) in order to obtain greater reimbursement, or (2) less than what is medically necessary for treatment of the patient (under-utilization) in order to keep costs low.

Each AH home health agency should ensure that management and oversight of employees and subcontracted services is adequate so that a change in quality of care, which may result in improper billing, will be detected.

Each AH home health agency will adhere to applicable state and federal licensing requirements and Medicare conditions of participation. The agency will notify the State entity

¹ Such reports may be made verbally to the supervisor, local director, local facility compliance officer for that agency, anonymously by calling the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities' compliance officer.

responsible for licensing or certification of any change in: (1) the persons with an ownership or control interest in the agency, (2) persons who are officers, directors, agents, or managing employees of the agency, and (3) the corporation, association, or other company responsible for management of the agency, as applicable.

Each AH home health agency should ensure that it does not refuse to provide services to patients, on the grounds of race, color, or national origin, or in any other unlawful manner discriminate against any person who is otherwise eligible for home health services.

Each AH home health agency should ensure that it does not discharge patients in violation of applicable statutes, regulations, and federal health care program requirements. Each agency has a duty to fully inform a beneficiary in advance of termination of services when further care or treatment for such patient is likely to be necessary.

3. Billing

a. Billing Policies.

Each AH home health agency should ensure that all claims for home health services submitted to the Medicare program, the Medicaid program or other payors are accurate and correctly identify the services ordered by a health professional authorized to order treatment and performed by the home health agency.

b. Patient Eligibility.

Each AH home health agency should ensure that the Medicare program is only billed for those patients who are eligible to receive home health services. An eligible beneficiary is one who: (i) is confined to the home; (ii) is under the care of a physician who establishes a plan of care; (iii) is in need of at least one of the following skilled services - intermittent skilled nursing services, physical therapy services, speech-language pathology services or continuing occupational therapy services; and (iv) receives home health services from a Medicare participating home health agency.

c. Covered Services.

Each AH home health agency should ensure that the Medicare program is only billed for those home health services provided to eligible patients that are medically reasonable and necessary, provided by qualified licensed clinical personnel, and qualify as covered services. "Covered services" mean: (i) part-time or intermittent nursing care furnished by or under the supervision of a registered nurse; (ii) physical therapy, occupational therapy, or speech pathology services; (iii) medical social services under the direction of a physician; (iv) part-time or intermittent home health aide services; (v) medical supplies (other than drugs or biologicals) and durable medical equipment; and (vi) services of interns and residents if the home health agency is owned or affiliated with a hospital that has an approved medical education program.

AH home health agencies will not submit claims to the Medicare program for: (i) drugs and biologicals; (ii) transportation; (iii) services that would not be covered if furnished as inpatient

hospital services; (iv) housekeeping services; (v) services covered under the ESRD program; (vi) prosthetic devices; (vii) medical social services provided to family members (except as provided in the Medicare regulations); (viii) inadequate or substandard care; (ix) unallowable costs associated with home health coordination²; and (x) any other non-covered services.

Additionally, the AH home health agencies will not submit claims to the Medicare program where: (i) an able and willing family member or other person is or will be providing services that adequately meet the patient's needs; and (ii) the services provided are duplicative of services being provided or that should be provided by assisted living facilities, hospitals, clinics, physicians, or other home health agencies.

d. Physician Certification Requirements.

Each AH home health agency should ensure that the Medicare program is only billed for home health services when (i) a physician has certified that the beneficiary: (a) needs or needed intermittent skilled nursing care, physical therapy, speech therapy, or (b) needs or continued to need occupational therapy, after the need for skilled nursing and physical or speech therapy services has ceased; (ii) a physician has certified that the home health services were required because the beneficiary was confined to the home (except when receiving outpatient services); (iii) a plan for furnishing the services has been established and is periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine, and who is not precluded from performing this function (as discussed below); and (iv) the services were furnished while the individual was under the care of a physician.

Each AH home health agency should ensure that the physician who signs the certificate of need for home health services is aware of the limitation on certification established by the Medicare program (i.e., eligibility requirements for home health services under Medicare). In addition, physicians who have a significant ownership interest or who have significant financial or contractual relationships with the home health agency are prohibited from certifying, recertifying or establishing and reviewing plans of treatment for patients of that home health agency. AH should ensure that it works with legal counsel to obtain the most up-to-date information on this issue and that AH provides the physicians who work with AH home health agencies with information necessary to ensure compliance with such requirements and prohibitions.

e. Physician Orders.

AH home health agencies should ensure that the plans of care prepared for home health agency patients and other physician orders for home health services are completed, signed and dated by the attending physician before any claims for services provided pursuant to that plan of care or physician order are submitted to the Medicare program. No physician orders or plans of care shall be backdated or filled out contrary to the ordering physician's oral or written instructions by AH home health agency employees. Reasonable steps should be taken to ensure that the physician's certification is authentic and has not been forged (see 3(j) below).

AH:

² See Provider Reimbursement Manual Section 2114 for further guidance.

AH home health agencies should ensure that each plan of care is signed and dated by the attending physician and received by the home health agency in accordance with applicable State regulations. AH home health agencies should ensure that each plan of care is reviewed and updated by the attending physician, in consultation with home health professional personnel, at least every sixty-two (62) days.

f. Selection of CPT or HCPCS Codes.

Each AH home health agency should ensure that the CPT or HCPCS codes that are used to bill Medicare or Medicaid, *most accurately* describe the services that were ordered and performed. To satisfy this goal, each AH home health agency should perform a periodic review of CPT/HCPCS codes submitted by such agency to ensure accuracy in coding and billing for home health services. This review should be performed by individuals (or a committee) with expertise in home health services and the claims submission process.³ This review process may also be included as part of the reimbursement audit conducted by the AH organization with which the home health agency is affiliated (as described in Part 1 of this Compliance Program). Home health agency personnel should (i) immediately report any actual or suspected coding abuse,⁴ including any potential “up-coding” and (ii) be encouraged to ask the facility compliance officer questions regarding code selection. Additionally, a home health agency may direct coding questions to (i) its Medicare carrier or intermediary and (ii) the CPT Coding Clearinghouse Service. Any instructions received from the Medicare carrier or the CPT Coding Clearinghouse should be documented in a memorandum. Any such memoranda should be retained by the home health agency. In some cases, it may be appropriate to follow up any conversations with a confirming letter. In such case, the home health agency should keep a copy of the confirming letter for its records.

g. Selection of ICD-9CM Codes.

Each AH home health agency should ensure that it only submits diagnostic information obtained from the ordering physician. Specifically, the home health agency should: (1) contact the ordering physician to obtain diagnostic information in the event that the physician has failed to provide such information; (2) only use diagnostic information supplied by the ordering physician when carrying out a standing order in connection with an extended course of treatment; and (3) accurately translate narrative diagnoses obtained from the physician to ICD-9CM codes.

AH home health agencies are prohibited from: (1) using diagnostic information provided by the physician from earlier dates of service (other than standing orders, as discussed below); (2) using “cheat sheets” that provide diagnostic information that has triggered reimbursement in the past; (3) using computer programs that automatically insert diagnosis codes without receipt of diagnostic information from the physician; or (4) making up diagnostic information for claim’s submission purposes. Any person aware of any such activity at an AH – home health agency should immediately notify the

³ Individuals involved in this process should not be exclusively billing or financial personnel.

⁴ Such reports may be made verbally to the supervisor, local director, local facility compliance officer for that agency, anonymously by calling the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities’ compliance officer.

local compliance officer.⁵

h. Documentation

Each AH home health agency should periodically verify that appropriate documentation supporting its claims exists, and that such documentation is being appropriately maintained in a legible form, and will be available for audit and review if necessary. Such documentation should include (i) the activity leading to the record entry; (ii) the identity of the individual providing the service; and (iii) any information necessary to support the medical necessity and other applicable reimbursement coverage criteria.

Each AH home health agency should ensure that amendments to nursing notes are dated when the amendment is actually made (i.e., any amendments to nursing notes should not be falsely dated).

Each AH home health agency should ensure that signatures on visit slips or logs verifying services performed are obtained only from the, patient or a responsible family member or companion, of the patient at the time the services are actually rendered.

i. Services Covered by Claims for Reimbursement

Each AH home health agency should ensure that it only submits claims for services that were both ordered and performed. The home health agency should not provide any home health agency services to its patients until a written or verbal order is obtained from the attending physician.

Each AH home health agency should ensure that it only submits claims for services which it actually provides.

Each AH home health agency should adopt procedures which ensure that duplicate claims are not submitted for the same service.

Any person aware of AH home health agency personnel not complying with these requirements should immediately notify the facility compliance officer.⁴

j. Review of Claims

AH home health agencies should implement and maintain a process for a periodic review of home health claims to ensure that such claims accurately represent medically necessary services actually provided, supported by sufficient documentation, and in conformity with applicable coverage criteria for reimbursement. At a minimum, this process should include: (i) an examination of the frequency and duration of services the home health agency provides to determine whether the patients' medical conditions justify the number of visits provided and billed; (ii) determining whether the patients have actually received the appropriate level and number of services billed by the home health

⁵ Such reports may be made verbally to the supervisor, local director, local facility compliance officer for that agency, anonymously by calling the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities' compliance officer.

agency; (iii) determining whether patients receiving home care are actually homebound and have a need for a qualifying service; and (iv) verification that home health services are ordered and authorized by a physician. Compliance issues discovered during this review process should be reported to the facility compliance officer.⁴

4. Financial Arrangements with Referring Physicians

AH home health agencies must comply with Part 2 of the Compliance Program with respect to any financial arrangement with physicians who may be in a position to refer patients to the home health agency. In addition, any home health joint venture between AH and physicians must comply with the standards set forth in Part 2 of the Compliance Program.

AH has developed a model medical director agreement for its home health agencies. This model agreement is attached hereto as Attachment 1. Instructional guidelines for the completion of this model agreement are attached as Attachment 2. AH home health agencies must follow the guidelines for review and approval by AH as contained in Part 2 of the Compliance Program when entering into medical director agreements with physicians.

5. Financial Arrangements with Providers and Suppliers

AH home health agencies may enter into agreements with various providers and suppliers such as home medical equipment vendors, infusion vendors, and other home health agencies. Agreements between AH home health agencies and these providers or suppliers must be in writing and must be consistent with the principles set forth in Part 1 of this Compliance Program. In particular, the agency should ensure that any such agreements do not violate any federal or state anti-kickback statutes or other fraud and abuse statutes, and that improper financial incentives are not included in such arrangements.

6. Compliance with Applicable HHS OIG Fraud Alerts

Each AH home health agency should comply with the requirements of fraud alerts that are issued by the government from time to time. AH compliance officers will, in consultation with legal counsel, disseminate applicable fraud alert requirements in the most effective and efficient manner to each AH home health agency. In addition, the actual fraud alert shall be forwarded to each AH home health agency by the local compliance officer. Such material should be readily accessible to home health agency personnel. Any questions regarding compliance with fraud alert requirements should be directed to the local compliance officer.

7. Prohibited Compensation Arrangements for Billing Staff and Billing Consultants

AH home health agencies should not compensate their billing department personnel or billing consultants in such a manner as to encourage submission of claims regardless of whether such claims meet applicable coverage criteria for reimbursement or accurately represent services rendered.

8. Marketing

AH home health agencies shall require honest, straightforward, fully informative

and non-deceptive marketing of home health services. All people responsible for preparing or approving marketing materials or plans shall periodically receive training and education. Such training shall focus on sales activities prohibited by federal and state law, including, the offering of anything of value in return for actual or potential referral of business, improper patient solicitation activities and high-pressure marketing of uncovered or unnecessary services, or compensation programs that emphasize incentives for number of visits performed and revenue generated. AH home health agencies shall also ensure that their employees are aware of the potential for improper influence over referrals which may be exerted where the patient is being discharged from a hospital related to the home health agency.

9. Credit Balances

Each AH home health agency should ensure that any improper or excess payment made to the home health agency as a result of patient billing or claims processing errors, is promptly returned or a provision, setting funds aside in a separate account, is made within a reasonable period of time after the agency becomes aware that an incorrect collection occurred.

10. Cost Report

For AH provider based home health agencies, reasonable costs of discharge planning services performed by AH home health personnel are allowable on the hospital's cost report when the costs are properly classified as costs of the hospital or SNF and do not represent a duplication of services performed by other personnel.

Each AH home health agency should ensure that the time spent by shared staff is appropriately allocated through payroll to the shared departments (i.e., hospice, private duty, etc.).

The cost report for provider based home health agencies is an integral subpart of the hospital's cost report. The hospital's chief financial officer is responsible for ensuring that the cost allocation formula and calculations accurately reflect the financial activities of the agency and conform to regulatory guidelines. The agency director is responsible for following hospital policies that ensure agency costs are properly recorded to meet regulatory requirements.

11. Training and Education

Each local compliance officer shall identify all ~~affected~~ employees with significant compliance responsibilities in their respective organization and provide appropriate training and education to these employees. Additionally, the Corporate Compliance Officer may periodically create and disseminate training videos and ~~material~~ materials to all employees for the purpose of compliance education.

12. Employees

a. Each person involved in the marketing or billing of home health agency services should (1) receive and review those home health agency policies and procedures applicable to each such person's job performance; (2) discuss with his/her supervisor or the supervisor's designee the

standards of conduct required under such policies; and (3) sign an acknowledgment, substantially in the form as Attachment 3, that he/she has complied with (1) and (2) herein and will abide by such policies. New employees involved in the provision, marketing, or billing of home health agency services, should also fulfill these requirements.

b. Each AH home health agency shall: 1) distribute to its employees a notice summarizing the compliance program, substantially in the form as Attachment 4, and 2) post in common working areas a notice of reporting options available to AH employees for addressing suspected violations of applicable policies, procedures and federal and state law in the conduct of its home health agency business. The notice shall be substantially in the form as Attachment 7 hereto.

13. Retention of Records

Generally, home health agency records should be maintained in accordance with AH's document retention guidelines after submission of the claim in question to the federally funded health care program. Upon the expiration of the retention period of the claim's submission to the applicable federally funded health care program, such documentation may be destroyed by the agency.

B. Anti-Kickback Statutes

Certain federal and state laws prohibit health care providers from paying for referrals. Each AH home health agency should ensure that the home health agency is not paying for referrals. Accordingly, no home health agency may (1) offer discounts or anything of value to physicians/other referral sources in order to induce the referral of patients to the home health agency; and (2) provide computers, fax machines or other equipment to referring health care providers.

C. Compliance with State Law

Each AH home health agency should ensure that it has obtained state licensure to operate as a home health agency and that it continues to meet all legal requirements for operating as a home health agency.

D. Miscellaneous

AH home health agencies should not:

a. participate in schemes that involve collusion between providers and/or suppliers that result in higher charges to Medicare; or

b. misrepresent (i) the services supplied by up-coding or use of inappropriate procedure codes; (ii) the amounts charged for the services rendered; (iii) the identity of the person receiving the services; or (iv) the date on which the services were performed.

IV.

POLICIES AND PROCEDURES FOR HOSPICE PROGRAMS

A. Introduction

1. Standards of Conduct

AH does not tolerate fraud and abuse by its agents or employees. Accordingly, it is AH's express intention that each and every hospice program employee and every hospice program volunteer prevent, discourage and/or halt any such fraud, waste, and abuse or unethical activity discovered. Any activity that violates this policy must be reported immediately to the facility compliance officer assigned to that hospice program.⁶

Moreover, AH encourages and expects full adherence to all guidelines and regulations governing federally funded health care programs, as distributed from time to time by the hospice program's fiscal intermediary/carrier or other government agency (e.g., new billing procedures, fraud alerts, etc.).

2. Billing

a. Billing Policies.

Each AH hospice program should ensure that all claims for hospice services submitted to Medicare, or other payors are accurate and correctly identify the services ordered by the physician and performed by the hospice program.

(1) Patient Eligibility.

Each AH hospice program should ensure that the Medicare program is only billed for those patients who are eligible to receive hospice services. An eligible beneficiary is one who is terminally ill and has a prognosis of six months or less if the illness runs its normal course. The hospice program must obtain an election form from each Medicare beneficiary which provides that the beneficiary has elected hospice care for a specific period. Such election forms shall be maintained in the patient's chart.

(2) Covered Services.

Each AH hospice program should ensure that the Medicare program is only billed for those hospice services provided to eligible patients that are covered services.

AH hospices should not submit claims to the Medicare program for services which are duplicative of other services already being provided to such patients, or that should be provided, by

⁶ Such reports may be made verbally to the supervisor, local director, local facility compliance officer for that agency, anonymously by calling the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities' compliance officer.

assisted living facilities, nursing homes, or other obligated organizations.

(3) Physician Certification Requirements.

Each AH hospice program should ensure that the Medicare program is only billed for hospice services if a physician has certified that the patient is terminally ill. The Medicare program considers a beneficiary to be terminally ill if there is a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course. Such certification shall be maintained in the patient's chart. For the initial 90-day election period, each AH hospice program must obtain written certification statements (and oral certification statements if required by the Medicare program) from (i) the medical director of the hospice program or the physician member of the hospice interdisciplinary group; and (ii) the beneficiary's attending physician if the beneficiary has an attending physician.

(4) Physician Orders.

AH hospice programs should ensure that plans of care and other physician orders prepared for hospice patients are completed, signed and dated by the attending physician before any claims for services provided pursuant to that plan of care or physician order are submitted to the Medicare program. No physician orders shall be backdated by AH hospice program employees.

AH hospice programs shall ensure that all plans of care are established by the attending physician, the hospice medical director or staff physician and the hospice interdisciplinary group prior to providing care.

(5) Services Covered by Claims for Reimbursement

Each AH hospice program should ensure that it only submits claims for services that were both ordered and performed. The hospice program should not provide any hospice services to its patients until a written or verbal order is obtained from the attending physician.

Any person aware of AH hospice personnel not complying with these requirements should immediately notify the facility compliance officer.⁷

(6) Review of Claims

AH hospice programs should implement and maintain a process for a periodic review of hospice claims to ensure that such claims accurately represent medically necessary services actually provided, supported by sufficient documentation, and in conformity with applicable coverage criteria for reimbursement. Compliance issues discovered during this review process should be reported to the facility compliance officer.⁴

3. Financial Arrangements with Referring Physicians

⁷ Such reports may be made verbally to the supervisor, local director, local facility compliance officer for that agency, anonymously by calling the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities' compliance officer.

AH hospice programs must comply with Part 2 of the Compliance Program with respect to any financial arrangement with physicians who may be in a position to refer patients to the hospice program.

AH has developed a model medical director agreement for its hospice programs. This model agreement and instructional guidelines are attached hereto as Attachment 5. Instructional guidelines for the completion of this model agreement are included in Attachment 2. AH hospice programs must follow the guidelines for review and approval by AH as contained in Part 2 of the Compliance Program when entering into medical director agreements with physicians.

4. Financial Arrangements with Providers and Suppliers

AH hospice programs may enter into agreements with various providers and suppliers such as home medical equipment vendors, pharmacies, skilled nursing facilities and hospitals. Agreements between AH hospice programs and these providers or suppliers must be in writing and must be consistent with the principles set forth in Part 1 of this Compliance Program. In particular, the AH hospice program should ensure that any such agreements do not violate any federal or state anti-kickback or other fraud and abuse statutes, and that improper financial incentives are not included in such arrangements.

If an AH hospice program provides hospice services to residents of skilled nursing facilities, the hospice program should enter into a written agreement with the skilled nursing facility and adhere to all requirements of the Medicare and Medi-Cal programs with respect to such agreements, including any requirements regarding payment limitations.

5. Compliance with Applicable HHS OIG Fraud Alerts

Each AH hospice program should comply with the requirements of fraud alerts that are issued by the government from time to time. AH compliance officers will, in consultation with legal counsel, disseminate applicable fraud alert requirements in the most effective and efficient manner to each AH hospice program. In addition, the actual fraud alert shall be forwarded to each AH hospice program by the facility compliance officer. Such material should be readily accessible to hospice program personnel. Any questions regarding compliance with fraud alert requirements should be directed to the facility compliance officer.

6. Marketing

AH hospice programs shall require honest, straightforward, fully informative and non-deceptive marketing of hospice services. All people responsible for preparing or approving marketing materials or plans shall periodically receive training and education. Such training shall focus on sales activities prohibited by federal and state law, including, the offering of anything of value in return for referral of business.

7. Cost Report

For AH provider based hospice programs, reasonable costs of discharge planning

services performed by AH hospice personnel are allowable on the hospital's cost report when the costs are properly classified as costs of the hospital or SNF and do not represent a duplication of services performed by other personnel.

Each AH hospice program should ensure that the time spent by shared staff is appropriately allocated through payroll to the shared departments (i.e., home health, private duty, etc.).

8. Employees

a. Each person involved in the provision, marketing or billing of hospice services, including all home health aides, should (1) receive and review those hospice program policies and procedures applicable to each such person's job performance; (2) discuss with his/her supervisor or the supervisor's designee the standards of conduct required under such policies; and (3) sign an acknowledgment, substantially in the form as Attachment 3, that he/she has complied with (1) and (2) herein and will abide by such policies. New employees involved in the provision, marketing, or billing of hospice program services, should also fulfill these requirements.

b. Each AH hospice program shall, 1) distribute to its employees a notice summarizing the compliance program, substantially in the form as Attachment 6, and 2) post in common working areas a notice of reporting options available to AH employees for addressing suspected violations of applicable policies, procedures and federal and state law in the conduct of its home health agency business. The notice shall be substantially in the form as Attachment 7 hereto.

9. Credit Balances

Each AH hospice program should ensure that any improper or excess payment made to the program as a result of patient billing or claims processing errors is promptly returned or a provision, setting funds aside in a separate account, is made within a reasonable period of time after the program becomes aware that an incorrect collection occurred.

10. Training and Education

Each local compliance officer shall identify all employees with significant compliance responsibilities in their respective organization and provide appropriate training and education to these employees. Additionally, the Corporate Compliance Officer may periodically create and disseminate training videos and materials to all employees for the purpose of compliance education.

11. Retention of Records

Generally, AH hospice program records should be maintained in accordance with AH's document retention guidelines after submission of the claim in question to the federally funded health care program. Upon the expiration of the retention period of the claim's submission to the applicable federally funded health care program, such documentation may be destroyed by the program.

B. Anti-Kickback Statutes

Certain federal and state laws prohibit health care providers from paying for referrals. Each AH hospice program should ensure that the hospice program is not paying for referrals. Accordingly, no hospice program may (1) offer discounts or anything of value to physicians/other referral sources in order to induce the referral of patients to the hospice program; and (2) provide computers, fax machines or other equipment to referring health care providers.

C. Compliance with State Law

Each AH hospice program should ensure that it has obtained state licensure to operate as a hospice program and that it continues to meet all Medicare conditions of participation and legal requirements for operating as a hospice program.

D. Miscellaneous

AH hospice programs should not:

- a. participate in schemes that involve collusion between providers and/or suppliers that result in higher charges to Medicare; or
- b. misrepresent (i) the services supplied by up-coding or use of inappropriate procedure codes; (ii) the amounts charged for the services rendered; (iii) the identity of the person receiving the services; or (iv) the date on which the services were performed.

Attachment 1

[Add Model Home Health Agency Medical Director Agreement]

Attachment 2

[Add Instructional Guidelines for Medical Director Agreements]

Attachment 3

**ADVENTIST HEALTH
HOME HEALTH AGENCIES AND HOSPICE
COMPLIANCE PROGRAM**

ACKNOWLEDGMENT OF RECEIPT AND REVIEW

I have received and read a copy of the Home Health Agencies And Hospice Compliance Program and agree to abide by the policies, rules and regulations contained therein.

I understand that this Home Health Agencies And Hospice Compliance Program is only a part of Adventist Health policies and that any violation may result in corrective and/or disciplinary action up to and including termination. Adventist Health reserves the right to modify these polices at its sole discretion.

Signature

Date

Attachment 4

NOTICE

**ADVENTIST HEALTH HOME HEALTH AND HOSPICE COMPLIANCE PROGRAM
A Personal Commitment to Integrity**

It is and has always been the policy of Adventist Health (“AH”) to fully comply with all laws, regulations and ethical requirements that apply to health care providers. To help ensure that AH and all AH employees continue to comply with these standards, AH has adopted a Home Health and Hospice Compliance Program which formalizes our compliance efforts into a comprehensive program which better defines the responsibilities of all AH employees regarding compliance issues.

AH’s Home Health and Hospice Compliance Program reflects AH’s strong commitment to comply with all laws and regulations affecting it’s home health agency operations.

Each AH home health agency will receive a copy of the Home Health and Hospice Compliance Program. In addition, a training and education program will help ensure that home health agency employees understand the standards of conduct that they are expected to follow.

The Home Health and Hospice Compliance Program is designed to *prevent* violations of applicable laws, regulations, policies and ethical requirements by helping employees choose the proper course of action when faced with difficult compliance issues. Specifically, the Compliance Program emphasizes training and encourages employees to seek advice whenever they are uncertain as to the proper course of action to take. An employee’s supervisor, local director, local facility compliance officer, and the Corporate Compliance Officer are always available to help answer any questions an employee may have concerning compliance issues.

The Home Health And Hospice Compliance Program is also designed to *detect and correct* violations of applicable laws, regulations, policies and ethical requirements. Therefore, it is the duty and responsibility of each employee to report promptly to an appropriate person any violation or potential violation of these standards.

The preferred method of reporting or communicating potential compliance issues or anything that may otherwise compromise the integrity of AH is for an employee to first try to speak to his or her supervisor directly. This is consistent with AH’s “open-door” policy. However, in certain situations, an employee may feel uncomfortable discussing a particular situation with his or her supervisor. Therefore, each employee is free to discuss or report any suspected misconduct or non-compliance to their local director, local facility compliance officer, or the Corporate Compliance Officer.

In addition, AH established a toll free telephone number, 1-888-366-3833, through which employees may submit confidential, and if desired, anonymous, reports. This reporting procedure allows employees to report suspected misconduct or non-compliance by bypassing normal channels of communication and chains of command. Suspected misconduct and non-compliance issues may also be reported through written reports. Compliance reporting forms are available through the AH home health agency’s human resource department and/or local compliance officer. To make a written report you may write to your local compliance officer or AH’s Corporate Compliance Officer at the addresses

below.

Employees are encouraged to identify themselves when making such reports so that the information can be investigated promptly and thoroughly. However, any report may be made on an anonymous basis. In addition, *no employee will suffer any penalty or retribution for reporting suspected misconduct or non-compliance.*

All such reports will be relayed to local compliance officer for investigation. Any AH employee who is found to have engaged in conduct on behalf of the company in violation of the Home Health and Hospice Compliance Program may be subject to prompt and appropriate discipline, up to and including dismissal.

Feel free to contact, verbally or in writing, the following with any questions or concerns you may have about the application of any law, regulation or company policy to your home health agency, or any suspected violation of law, company policy or Home Health and Hospice Compliance Program.

[Local Compliance Officer]

[Facility]

[Address]

[City], [State] [Zip]

Tel: (xxx) xxx-xxxx

Fax: (xxx) xxx-xxxx

Corporate Compliance Officer

Adventist Health

2100 Douglas Boulevard

P. O. Box 619002

Roseville, CA 95661-9002

Tel: (916) 781-4730

Fax: (916) 774-3326

Attachment 5

[Add Model Hospice Medical Director Agreement]

Attachment 6

NOTICE

**ADVENTIST HEALTH HOME HEALTH AND HOSPICE COMPLIANCE PROGRAM
A Personal Commitment to Integrity**

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AH’s Home Health and Hospice Compliance Program reflects AH’s strong commitment to comply with all laws and regulations affecting it’s hospice program operations.

Each AH hospice program will receive a copy of the Home Health and Hospice Compliance Program. In addition, a training and education program will help ensure that hospice program employees understand the standards of conduct that they are expected to follow.

The Home Health And Hospice Compliance Program is designed to *prevent* violations of applicable laws, regulations, policies and ethical requirements by helping employees choose the proper course of action when faced with difficult compliance issues. Specifically, the Compliance Program emphasizes training and encourages employees to seek advice whenever they are uncertain as to the proper course of action to take. An employee’s supervisor, local director, local facility compliance officer, and the Corporate Compliance Officer are always available to help answer any questions an employee may have concerning compliance issues.

The Home Health And Hospice Compliance Program is also designed to *detect and correct* violations of applicable laws, regulations, policies and ethical requirements. Therefore, it is the duty and responsibility of each employee to report promptly to an appropriate person any violation or potential violation of these standards.

The preferred method of reporting or communicating potential compliance issues or anything that may otherwise compromise the integrity of AH is for an employee to first try to speak to his or her supervisor directly. This is consistent with AH’s “open-door” policy. However, in certain situations, an employee may feel uncomfortable discussing a particular situation with his or her supervisor. Therefore, each employee is free to discuss or report any suspected misconduct or non-compliance to their local director, facility compliance officer, or the Corporate Compliance Officer.

In addition, AH established a toll free telephone number, 1-888-366-3833, through which employees may submit confidential, and if desired, anonymous, reports. This reporting procedure allows employees to report suspected misconduct or non-compliance by bypassing normal channels of communication and chains of command. Suspected misconduct and non-compliance issues may also be

reported through written reports. Compliance reporting forms are available through the AH hospice's human resource department and/or local compliance officer. To make a written report you may write to local compliance officer or AH's Corporate Compliance Officer at the address below.

Employees are encouraged to identify themselves when making such reports so that the information can be investigated promptly and thoroughly. However, any report may be made on an anonymous basis. In addition, *no employee will suffer any penalty or retribution for reporting suspected misconduct or non-compliance.*

All such reports will be relayed to [local compliance officer] for investigation. Any AH employee who is found to have engaged in conduct on behalf of the company in violation of the Home Health and Hospice Compliance Program may be subject to prompt and appropriate discipline, up to and including dismissal.

Feel free to contact, verbally or in writing, the following with any questions or concerns you may have about the application of any law, regulation or company policy to your hospice program, or any suspected violation of law, company policy or Home Health and Hospice Compliance Program.

[Local Compliance Officer]

[Facility]

[Address]

[City], [State] [Zip]

Tel: (xxx) xxx-xxxx

Fax: (xxx) xxx-xxxx

Corporate Compliance Officer

Adventist Health

2100 Douglas Boulevard

P. O. Box 619002

Roseville, CA 95661-9002

Tel: (916) 781-4730

Fax: (916) 774-3326

Attachment 7

ADVENTIST HEALTH HOME HEALTH AND HOSPICE COMPLIANCE PROGRAM
Reporting Compliance Concerns

Adventist Health supports and encourages each employee to maintain individual responsibility for monitoring and reporting any activity by any employee or contractor that appears to violate any applicable laws, rules, regulations or this Compliance Program. Adventist Health's self-monitoring compliance program provides a confidential reporting system with the following options available for handling your Compliance Program concerns:

- Supervisor
- Local Compliance Officer- Currently the Local Compliance Officer is [*INSERT NAME OF LOCAL COMPLIANCE OFFICER*], who can be reach at (____-____-____).
- Compliance Report Form- The forms are available from various locations in your facility, your human resource department, and your Local Compliance Officer.
- Hotline- A special toll-free telephone line is dedicated to reporting Compliance Program concerns. Please be prepared to provide details of the situation. The toll-free number is 1-888-366-3833 (Operators are available 8 a.m. to 5 p.m. Pacific Time, Monday-Thursday; 8 a.m. to 3:30 p.m. Pacific Time, Friday. Messages may be left during weekends and after-hours).
- Corporate Compliance Officer- Adventist Health, P. O. Box 619002, Roseville, CA 95661-9002.



Facility:

System-wide Corporate Policy

Standard Policy

Model Policy:

Policy No.

Page 1 of 5

Department:

Category/Section:

Manual:

AP-100

Home Care

Administrative

Home Health

POLICY: HOME HEALTH BILLING POLICY AND PROCEDURE

POLICY SUMMARY/INTENT:

Enhance system billing compliance with state and federal regulatory guidelines and standardize billing processes.

DEFINITIONS:

AH: Adventist Health

POLICY:

The Agency does not offer, pay or receive payment of any kind in exchange for the referral of patients, services, or other business.

Each biller/office staff member will maintain a high ethical standard in conducting home health business related to billing and office processes. They will comply with the AH Corporate compliance program, state and federal regulations, JCAHO standards, and Medicare conditions of participation.

A. INTAKE/REFERRAL

1. Agency personnel should employ reasonable measures to verify that:
 - a. The referring physician is appropriately licensed and that
 - b. No adverse actions, such as criminal conviction, debarment, or an exclusion, have been taken against the physician.
 - c. *Reasonable measures* may include but are not limited to obtaining and verifying physician information through:
 - 1.) Physician list obtained from hospital medical staff office,
 - 2.) Phone verification with the state licensing board,
 - 3.) Internet, or
 - 4.) Commercial publications available through subscription.
2. Insurance and benefit coverage will be verified for each patient.
 - a. Intake/Admitting personnel shall identify those patients who are uninsured or under-insured, determine the financial status of identified patients and assist potential charity patients in applying for eligibility. In all applicable cases, the patient should be encouraged to apply for assistance through state, county and other programs before charity care is applied.

Revised June 8, 2000

- b. Charity care eligibility will be determined in accordance with the affiliated AH hospital's policies and procedures.
3. The doctor's initial assessment states that the beneficiary qualifies for home health care.
4. Medicare/Medicaid patients will only be accepted if the AH home health agency has a valid agreement to participate in Medicare/Medicaid. If it is determined that the patient is covered by Medicare/Medicaid, the intake/office personnel must include the following documentation before intake/referral can be completed.
 - a. The patient is an eligible Medicare/Medicaid beneficiary
 - b. Medicare/Medicaid and not another payor is the appropriate payer.
5. Patient/family will be informed of coverage of benefits and charges, including co-pays, before services are provided. Any change in the charges, coverage or benefits, or the agency's understanding of them, will be communicated to the patient/family promptly and in writing. The agency will maintain and keep documentation supporting the patient/family's knowledge and consent to the charges, coverage and benefits.
6. Patient/family will be notified of any financial arrangement/ownership the agency has in any business to which the patient may be referred (e.g. HME, HIT, Hospice).
7. Patient must meet the admission criteria specified in the Home Health Policy Manual (Admission Criteria AP-108).

B. BILLING

1. Prior to submission of a claim for reimbursement, documentation supporting the claim must be maintained, appropriately organized in a legible form, and be available for audit and review.
 - a. Provider notes must contain complete and appropriate documentation necessary to substantiate the homebound status of the home health beneficiary and that services being provided are medically reasonable and necessary.
 - b. Provider notes must contain documentation whether there is a family member or caregiver that is both willing and able to participate in providing services that adequately meet the patient's needs.
 - c. Plan of care and subsequent orders must be established, dated, and signed by a qualified physician or authorized healthcare professional, as defined by state and federal regulation.
 - 1.) The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with home health agency professional personnel, at least every 62 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review. If the plan of care and orders are signed but not dated by physician, a date stamp must be used to document the date the plan of care or orders were received by the home health agency.
 - 2.) The plan of care must contain the physician certification that services provided are medically reasonable and necessary and that:

- a.) The patient is confined to the home as defined by HIM 11 §204.1 (note exception if private payor or if stipulated by payor/plan)
 - b.) The patient is in need of intermittent skilled nursing care; physical, speech or occupational therapy, or other services as defined by individual payor/plans
 - c.) The patient is under the care of the physician while the services are being furnished, and
 - d.) A plan of care has been established and is periodically reviewed by the physician.
- 3.) Agency should have on file the physician's signature, which can be compared to the plan of care and orders to ensure that the physician's signature has not been forged.
- d. Documentation must include verification that the beneficiary actually received the appropriate level and number of services being billed. For each claim of services provided, verification should be in the form of the beneficiary/family/caregiver's signature on the home visit record or visit note acknowledging services received.
 - e. Documentation must support that the level and number of visits provided agrees to those ordered by the physician in the plan of care and subsequent orders.
2. The biller/office personnel will process claims in compliance with state and federal regulations, Medicare conditions of participation, and AH Corporate compliance program.
- a. Coding of services will accurately reflect the services rendered. Diagnosis and procedure codes reported on the reimbursement claim will be based on the patient's medical record and other documentation, as well as be in compliance with all applicable official coding rules and guidelines. HCPCS, ICD-9CM, and CPT codes used by the billing staff will accurately describe the service that was ordered by the physician and performed by the home health agency.
 - b. Claims will only include charges for covered services and supplies provided to eligible patients. Any non-covered service or supply, as defined by payor, will not be submitted for reimbursement.
 - c. Claims will not be submitted to the Medicare program or any other program for provided services that are duplicative of services being provided or that are required to be provided by assisted living facilities, hospitals, clinics, physicians, or other home health agencies.
 - d. Claims will not be submitted for reimbursement if documentation is incomplete, insufficient to show that services were performed, or unable to support reimbursement.
 - e. Claims will be reviewed for errors or duplicate billing of services. These claims will then be matched to service reports and medical records before sending to the customer/payor. Claims will not be submitted until completeness and accuracy have been verified.
- 1.) Billing/Office personnel will run a billing report which shows: financial class, account number, patient name, date of service, charge number, charge description and amount to be billed.

- 2.) Billing/Office personnel will verify that there are notes and signed orders supporting each patient charge shown on the billing report, and that subsequent orders are completed and signed by the physician or other authorized healthcare professional, as defined by state and federal regulations, prior to billing. Corrections will be made to the claims as necessary to assure accuracy.
- 3.) Billing/Office personnel will print bills (or review bills online) and compare to billing report for accuracy.
- f. All manual and electronic claims will be formatted and submitted as required by payor.
3. All claims, which are supported by appropriate documentation and meet all requirements for a proper claim, will be submitted to the appropriate payor for reimbursement.

C. POST SUBMISSION OF CLAIMS

1. Billing/Office personnel will follow up on submitted claims, checking for Additional Data Requests (ADR's), errors or denials. Corrections and resubmission of claims denied will be made when appropriate and in compliance with regulatory guidelines. Relevant documentation supporting claims will be submitted to the requesting payor in response to the ADR within the identified timeline.
2. Duties/functions related to the handling of cash receipts/payments will be kept separate from the duties/functions related to the posting of receivables and payments to patient accounts.
3. Upon receipt of payment, cash or Remittance Advice (both manual and electronic), will be posted to each patient's account in a manner that the receivable will be identified as having been paid.
4. Billing/Office personnel will review the 'Patient A/R Aging' report for amounts still outstanding. Personnel will investigate with payor the claim status and reason for unpaid claim and, when acceptable, re-submit claim for reimbursement.
5. Disputes regarding billed claims/invoices will be promptly investigated and resolved.
6. Bad debt write-offs, refunds, discounts, and other non-contractual adjustments to patient accounts must be approved by the director prior to any adjustment taking place.
7. Payments incorrectly received will be promptly returned to payor or a provision, setting funds aside in a separate account, will be made within a reasonable period of time after the agency becomes aware that an incorrect collection occurred.
 - a. Within 30 days of the close of each calendar quarter, form HCFA-838 will be submitted to the Regional Home Health Intermediary reporting all Medicare credit balances shown in agency accounting records as of the last day of the reporting quarter.
 - b. Billing/Office personnel should maintain documentation supporting each patient record with a credit balance attributable to Medicare and the amount owed. Such documentation should include, but not be limited to, the following:
 - 1.) Whether or not the patient is an eligible Medicare beneficiary,
 - 2.) Other liable insurers and the primary payer, and

- 3.) Adherence to applicable Medicare payment rules
8. Supervisory/Quality personnel will perform periodic unscheduled quality checks on the billing process by selecting and reviewing a judgmental sample of claims, prior to submission for reimbursement, in order to verify that they are properly maintained and supported by necessary and complete documentation. Documentation should be maintained in a legible form and be available for audit and review if necessary. Such documentation should include, but not be limited to, the following:
- a. Activity leading to the record entry,
 - b. Identity of the individual providing the service, and
 - c. Any information necessary to support the medical necessity and other applicable reimbursement coverage criteria.

APPLICABLE STANDARDS OR REGULATORY REQUIREMENTS: HIM 11: 203, 204, 245, 489; 42CFR: 484 conditions of participation; JCAHO: RI.1, RI.1.1, RI.1.1.1, RI.2, RI.3, RI.4, TX.2, TX.2.1, TX.2.1.1, TX.3, CC.1, CC.6, LO.5, LO.8, LO.12, IM.2, IM.9.9, IM.9.15, IM.9.19;

REFERENCES: Medicare Conditions of Participation, Medicare Provider Reimbursement Manual, Code of Federal Regulations

AUTHOR: Bill Wiedemann

APPROVED: Adventist Health Senior Leadership Team (SLT) (#FI04001-S)

EFFECTIVE DATE: June 15, 1999

DISTRIBUTION: Home Health Directors, Hospital PBO Directors, Home Health Billers, AHEC, CFO, PCE

REVIEWED: Annually

REVISION: June 8, 2000

POLICY HISTORY: New Policy

ATTACHMENTS:



Facility:

System-wide Corporate Policy

Standard Policy

Model Policy:

Policy No.

Page 1 of 3

Department:

Category/Section:

Manual:

AP-101

Home Care

Administrative

Home Health

POLICY: HOME HEALTH BILLING AUDIT

POLICY SUMMARY/INTENT:

Ensure billing procedure is operating as intended and is in compliance with regulatory guidelines.

DEFINITIONS:

AH (Adventist Health)

AUDIT – An audit is the process of checking, on a test basis, a process or procedure that has already been performed to determine whether the process or procedure is working as intended.

BILLING REVIEW – Billing review is the detail work performed, prior to claim submission, by the person(s) responsible for the billing process for the purpose of ensuring that all claims are free of errors and are in compliance with regulatory guidelines.

INDEPENDENT PERSON – An independent person is someone who is not involved in preparing the claims for billing or involved in the billing review process.

POLICY:

Billing and claims submission is a key element in home health compliance. Each person selected to perform audits of the billing process will maintain a high ethical standard in conducting home health audits related to billing and office processes. They will plan and execute the audit in a manner which ensures that claims comply with the AH Corporate compliance program, state and federal regulations, JCAHO standards, and Medicare conditions of participation.

A. The audit will be performed by the appropriate person(s) defined as follows:

1. A person with authoritative knowledge of health care compliance requirements and who is *independent* of the billing review and claims process must perform the billing/claim audit. This person may be an internal employee, qualified employee from an affiliated agency, or an external contractor. If an internal employee, this person would usually be the quality coordinator, supervisor, or another person who has adequate knowledge of billing requirements and is independent of the billing process.
2. The independent person performing the audit will select a sampling of claims, which have been prepared and reviewed by billing personnel and are ready for submission to payor, and compare the claims to nursing notes, physician orders, and other items in the medical records as outlined in the Home Health Billing Policy (AP-100).
3. This audit procedure is not intended to replace the current billing review procedures performed by billing personnel which verify information prior to billing, rather it is an additional step which verifies that those billing procedures being performed are working appropriately.
4. Periodically, the audit process will be reviewed by auditors from Adventist Health Corporate office or by external auditors hired by Adventist Health. The results of this review will be examined by the local compliance officer and by the corporate compliance officer.

Revised June 8, 2000

- B. The frequency and timing of the audit will occur at regular intervals on a prescribed number of claims as described below.
1. The Agency will perform an annual routine audit of 5% of all claims up to a maximum of 15 claims based on total claims of the quarter *preceding* the annual Agency evaluation. Example: if a total of 260 claims were submitted in the quarter preceding the Agency evaluation, the Agency would select 13 claims (260 claims x 5%) to audit in the current quarter.
 2. The claims will be selected after the billing review has been performed but prior to claim submission for reimbursement. Thus any errors found during the course of the audit may be followed up and corrected prior to submission of the claims.
 3. The claim selection will consist of a judgmental selection of claims by the independent person performing the audit.
 4. The claim selection and routine audit will be performed once a year in conjunction with the annual Agency evaluation unless either of the following conditions occur.
 - a. DEFICIENCIES – If there are deficiencies noted during the audit, the Agency will continue performing interim special audits of 5% of claims up to a maximum of 10, on a quarterly basis until the Agency achieves two (2) clean audits consisting of no deficiencies. This follow up audit will only focus on the problems identified in the initial audit.
 - b. CHANGE IN KEY PERSONNEL – If there is a change in key personnel (e.g., billing, supervisory, or other positions with responsibility in the billing process), the audits will occur on a quarterly basis until the audit results in no deficiencies for two (2) consecutive audits. The interim special audit will consist of 5% of claims up to 15 claims for the quarter following a change in key personnel. Follow up audits will be performed for deficiencies as described in the preceding paragraph.
 5. The billing/claim audit may be spread out over the three (3) months included in the quarter (e.g., five claims may be audited in January, five in February, and five in March, for a total of 15 claims).
- C. Analysis of the audit results will be reviewed at both the local and corporate levels.
1. Audit results will be compiled at the Agency and forwarded to the local compliance officer and the Corporate Home Care Department. A baseline will be established and audit results will be monitored so that management, the local and corporate compliance officers, and the Corporate Home Care Department may judge the home health agencies progress in reducing or eliminating potential areas of billing/claim vulnerability.
 2. The Agency will review the audit results, identify, document, and make corrective changes to the billing process and procedures that will further enhance future compliance with regulatory guidelines.
 3. Significant variations from the baseline will trigger a reasonable inquiry to determine the cause of the deviation.
 - a. If the inquiry determines that the deviation occurred for legitimate, explainable reasons, management may limit any corrective action or take no action, as considered appropriate.
 - b. If the inquiry determines that the deviation was caused by improper procedures, misunderstanding of rules, systemic problems, or intentional fraud, management will take

prompt steps to correct the problem. Such steps may range from compliance education to employee termination.

APPLICABLE STANDARDS OR REGULATORY REQUIREMENTS: HIM 11: 203, 204, 245, 489; 42CFR: 484 conditions of participation; JCAHO: RI.1, RI1.1, RI1.1.1, RI.2, RI.3, RI.4, TX.2, TX.2.1, TX.2.1.1, TX.3, CC.1, CC.6, LO.5, LO.8, LO.12, IM.2, IM.9.9, IM.9.15, IM.9.19;

REFERENCES: Medicare Conditions of Participation, Medicare Provider Reimbursement Manual, Code of Federal **Regulations**

AUTHOR: Bill Wiedemann

APPROVED: Adventist Health Senior Leadership Team (SLT) (#FI04034-S)

EFFECTIVE DATE: June 8, 2000

DISTRIBUTION: Home Health Directors, Hospital PBO Directors, Home Health Billers, AHEC, CFO, PCE

REVIEWED: Annually

REVISION:

POLICY HISTORY: New

ATTACHMENTS:

**HOME HEALTH
BILLING AUDIT TOOL**

PERIOD COVERED BY CLAIM	
FROM: _____	TO: _____
ANNUAL ROUTINE AUDIT	<input type="checkbox"/>
INTERIM SPECIAL AUDIT	<input type="checkbox"/>
REVIEW DATE: _____	
QUARTER:	1 2 3 4
MEDICAL RECORD #: _____	
or PT ACCOUNT #: _____	

INSTRUCTIONS:

- The following questions are to be completed **prior to submission** of bills to the intermediary.
- Complete this form for each claim reviewed.
- The audit is to be completed by a person **independent** of the billing process, who has authoritative knowledge of home health compliance requirements.
- For each "NO" answer (under payor questions), identify the problem and the corrective action taken.

MEDICARE/MEDICAID ELIGIBILITY QUESTIONS	YES	NO	COMMENTS / ACTION TAKEN
1. Is the patient an eligible Medicare/Medicaid beneficiary? (If "NO", skip #2)			
2. Is Medicare/Medicaid the appropriate payor? (MSP form completed) NOTE: Medicare HMO is not the same as Medicare			

ALL PAYOR QUESTIONS	YES	NO	COMMENTS / ACTION TAKEN
3. Is there a signed and dated note for every visit listed on the bill?			
4. Do all notes or home visit records have a beneficiary/family/caregiver's signature acknowledging services received? *			
5. Are there physician orders covering all visits listed on the bill?			
6. Are ALL physician orders (including the 485) signed for the billing period?			
7. Are ALL physician orders (including the 485) dated by the physician or date stamped by the agency with the date the order was received?			
8. Is the diagnosis code on the bill the same as the diagnosis code on the HCFA-485?			
9. Are all items listed on the bill covered services and/or covered supplies?			
10. Are all services and/or supplies listed on the bill only once? (No Duplicate Charges)			

Signature/Title _____

* Results for process improvement. Does not require new quarterly review.

SUMMARY REPORT
HOME HEALTH BILLING AUDIT TOOL

PERIOD COVERED BY AUDIT	
FROM: _____	TO: _____
ANNUAL ROUTINE AUDIT	<input type="checkbox"/>
INTERIM SPECIAL AUDIT	<input type="checkbox"/>
QUARTER: 1 2 3 4	
YEAR: _____	

INSTRUCTIONS:

- Summarize the results shown on the HH Billing Audit Tool, noting the number of "Yes" and "No" responses.
- If billing audits are performed more than once-a-year, prepare a summary for each quarter audits are performed. See "Annual Summary Report" for summarization of quarterly information.
- Total claims reviewed should equal 5% of the previous quarters claims up to a maximum of 15 claims.
- For each "NO" answer, perform followup reviews in subsequent quarters until two clean audits are achieved.
- **Forward the completed Summary Report to Local Compliance Officer & Corporate Home Care Department.**

TOTAL NUMBER OF CLAIMS REVIEWED

MEDICARE/MEDICAID ELIGIBILITY QUESTIONS	# YES	# NO	COMMENTS / ACTION TAKEN
1. Is the patient an eligible Medicare/Medicaid beneficiary? (If no, Skip # 2)			
2. Is Medicare/Medicaid the appropriate payor? (MSP form completed)			

ALL PAYOR QUESTIONS	#YES	# NO	COMMENTS / ACTION TAKEN
3. Is there a signed and dated note for every visit listed on the bill?			
4. Do all notes or home visit records have a beneficiary/family/caregiver's signature acknowledging services received? *			
5. Are there physician orders covering all visits listed on the bill?			
6. Are ALL physician orders (including the 485) signed for the billing period?			
7. Are ALL physician orders (including the 485) dated by the physician or date stamped by the agency with the date the order was received?			
8. Is the diagnosis code on the bill the same as the diagnosis code on the HCFA-485?			
9. Are all items listed on the bill covered services and/or covered supplies?			
10. Are all services and/or supplies listed on the bill only once? (no duplicate charges)			

Summary/Conclusions/Education Provided:

Summarized by: Signature/Title _____

Date _____

* Results for process improvement. Does not require new quarterly review.



Home Care Services

ANNUAL SUMMARY REPORT HOME HEALTH BILLING AUDIT FOR YEAR _____

INSTRUCTIONS:

- Summarize the results shown on the quarterly billing summary reports, noting the number of "Yes" and "No" answers.
- **Forward the audit results to the Local Compliance Officer & Corporate Home Care Department for review.**
- This form is only required if more than one (1) audit is performed in a year.

QUESTIONS	Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
	# YES	# NO	# YES	# NO	# YES	# NO	# YES	# NO	# YES	# NO
1. Is the patient an eligible Medicare/Medicaid beneficiary? (If no, Skip # 2)										
2. Is Medicare/Medicaid the appropriate payer? (MSP form completed)										

QUESTIONS	Qtr 1		Qtr 2		Qtr 3		Qtr 4		Total	
	# YES	# NO	# YES	# NO	# YES	# NO	# YES	# NO	# YES	# NO
3. Is there a signed and dated note for every visit listed on the bill?										
4. Do all notes or home visit records have a beneficiary/family/caregiver's signature acknowledging services received? *										
5. Are there physician orders covering all visits listed on the bill?										
6. Are ALL physician orders (including the 485) signed for the billing period?										
7. Are ALL physician orders (including the 485) dated by the physician or date stamped by the agency with the date the order was received?										
8. Is the diagnosis code on the bill the same as the diagnosis code on the HCFA-485 Form?										
9. Are all items listed on the bill covered services and/or covered supplies?										
10. Are all services and/or supplies listed on the bill only once? (<u>no</u> duplicate charges?)										

Signature/Title: _____

* Results for process improvement. Does not require new quarterly review.

Adventist Health
Corporate Compliance Program
Part 4: Clinical Laboratories
Checklist

Actions relating to the Compliance Program Specifically:

- _____ Review the compliance program with laboratory personnel annually.
- _____ Distribute the notice entitled, “A Personal Commitment to Integrity” to each employee.
- _____ Obtain signed “Acknowledgement of Receipt and Review” from each employee.
- _____ Post the “Reporting Compliance Concerns” in a location each employee can view periodically.
- _____ Have the “Compliance Report” form available where employees can pick it up anonymously. These should be available so that employees can use them to report compliance concerns.

Actions required by the Compliance Program Concerning Operations:

Standards of Conduct:

- _____ Requires each employee to report fraud, waste, abuse, and/or unethical activity.
- _____ Staff must comply with pertinent government regulations.
- _____ Staff should seek advice when they are uncertain about the proper course of action.

Medical Necessity

- _____ The laboratory must submit claims only for medically necessary services, as far as the laboratory is able to know.
- _____ Maintain laboratory requisition forms in accordance with AH record retention policy.
- _____ Design requisition forms to emphasize physician choice so that they can order only those tests they believe are appropriate for each patient.
- _____ The requisition form should follow the model form. The local compliance officer should approve deviations. Customized requisition forms should be reviewed and approved by the local compliance officer.
- _____ The laboratory should notify, in writing, its physician clients annually regarding its Medicare billing requirements.
- _____ Obtain a signed acknowledgment from physicians requesting customized panels or requisition forms.
- _____ The laboratory will annually analyze test utilization for the 30 most frequently ordered tests.

Billing

- _____ Submitted claims must accurately reflect services provided.
- _____ CPT & HCPCS codes must accurately describe the services ordered and performed.
- _____ Only diagnostic information obtained from the attending physician must be used when billing.

Adventist Health
Corporate Compliance Program
Part 4: Clinical Laboratories
Checklist

- _____ Only submit claims for services both ordered and performed. Written or verbal orders must be obtained from the attending physician prior to providing the services.
- _____ Multichannel chemistry tests will be billed according to CMS approved panels.
- _____ Laboratory is prohibited from billing for both calculations and hematology indices
- _____ Laboratory will use Advanced Beneficiary Notices.
- _____ Standing orders should be verified every six (6) months.
- _____ Laboratory should identify tests subject to an all-inclusive rate, (e.g. Rural Health Clinic) and make sure they are not billed to the Medicare program separately.
- _____ Lab tests for ESRD patients must meet specific regulations.
- _____ Lab tests provided to hospital inpatients must not be billed separately from the IP claim.
- _____ Lab tests provided to outpatients up to 3 days prior to an IP admission must be combined with the inpatient claim.
- _____ Labs should not bill follow-up/repeat tests.
- _____ Lab tests performed multiple times in one day are not generally billable to Medicare.

OIG Fraud Alerts

- _____ Each AH Agency must comply with the OIG Fraud Alerts that are periodically published on the OIG web site.

Marketing

- _____ The agency must ensure that all marketing is honest, straightforward, informative, and non-deceptive and that staff and contracted agencies involved in marketing are properly trained concerning such activities.

Prices charged to Physicians

- _____ Profile pricing must be above cost and increase as tests are added to the profile.

Record Retention

- _____ The agency shall conform to the AH record retention policies.

Training and Education

- _____ All employees shall receive compliance training as appropriate to their responsibilities.

Financial Arrangements with Referring Physicians

- _____ Financial arrangements with referring physicians must comply with the AH Referral Source Compliance Program

Financial Arrangements with Providers and Suppliers

- _____ Agreements must be in writing and consistent with the principles of the AH Compliance Program.
- _____ Laboratory will not engage a billing consultant to maximize revenues using a commission based financial arrangement based on the resulting gains.

Adventist Health
Corporate Compliance Program
Part 4: Clinical Laboratories
Checklist

Anti-kickback Statutes

_____ Agency shall not pay for referrals.

CLIA Laws

_____ Agency shall comply with applicable CLIA regulations.

State Laws

_____ Laboratory will comply with all applicable state laws.

Miscellaneous

_____ AH Labs will not participate in schemes that result in higher charges to Medicare than otherwise permissible, utilize split billing schemes, or misrepresent services provided.

**PRIVILEGED AND CONFIDENTIAL
ATTORNEY-CLIENT COMMUNICATION
ATTORNEY WORK PRODUCT**

July 10, 1998

**ADVENTIST HEALTH
Corporate Compliance Program**

PART 4: CLINICAL LABORATORIES

I.

INTRODUCTION

Adventist Health and its affiliates (collectively referred to as “AH”) have established the following policies and procedures for clinical laboratories in its efforts to ensure full compliance with applicable federal and state law.

This Part 4 of the Compliance Program establishes AH’s policies and procedures regarding compliance with laws specific to clinical laboratories. These policies and procedures are intended to assure that AH-affiliated laboratories and such laboratories’ agents and employees comply with (i) applicable law, (ii) billing protocols established by such laboratories’ fiscal intermediaries/carriers, and (iii) the Medicare program’s rules concerning “medical necessity” of laboratory tests performed by laboratories and billed to the Medicare program.

II.

INTENT

It is the policy of AH to fully comply with all laws, regulations and ethical requirements that apply to health care providers. To help ensure that AH and all AH employees comply with these standards, AH has adopted these policies and procedures.

These policies and procedures reflect AH’s strong commitment to comply with all laws and regulations affecting its laboratory operations.

Each AH-affiliated laboratory will receive a copy of these policies and procedures. In addition, a training and education program will help ensure that laboratory employees understand the standards of conduct that they are expected to follow.

These laboratory policies and procedures are designed to *prevent* violations of applicable laws, regulations, policies and ethical requirements by helping employees choose the proper course of action when faced with difficult compliance issues. Specifically, the policies and procedures emphasize training and encourage employees to seek advice whenever they are uncertain as to the

proper course of action. An employee's supervisor, department director, local facility compliance officer, and AH's Corporate Compliance Officer are always available to answer any questions an employee may have concerning compliance issues.

These policies and procedures are also designed to *detect and correct* violations of applicable laws, regulations, policies and ethical requirements. Therefore, it is the duty and responsibility of each employee to report promptly to an appropriate person any violation or potential violation of these standards.

III.

POLICIES AND PROCEDURES FOR CLINICAL LABORATORIES

A. Introduction

1. Standards of Conduct

AH does not tolerate reimbursement fraud and abuse by its agents or employees. Accordingly, it is AH's express intention and company policy that each and every laboratory employee prevent, discourage, halt, and report any fraud, abuse, waste or unethical activity the employee discovers. In addition, any such activity should be reported immediately to the laboratory's facility compliance officer.¹

Moreover, AH expects full adherence by its employees and agents to all guidelines and regulations governing federally funded health care programs, as distributed from time to time by the laboratory's federal intermediary/carrier or other governmental agency (e.g., new billing procedures, fraud alerts, etc.).

2. Medical Necessity

AH-affiliated laboratories should not submit claims to a payer for services that the laboratory has reason to believe are not medically necessary (other than as discussed in Section 3b, below). Each AH-affiliated laboratory should establish and maintain a document retention program that requires the laboratory to retain requisition forms containing diagnosis codes supporting the medical necessity of a service the laboratory has provided and billed to a federal program. The laboratory should maintain such records in accordance with AH's document retention guidelines. Upon the expiration of the retention period the documents should be destroyed by the laboratory.

a. Requisition Design.

¹ Such reports may also be made verbally to the supervisor, department director, local facility compliance officer, the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities' compliance officer. Please clearly indicate on the report if anonymity is desired.

Each AH-affiliated laboratory should standardize its' non-customized test offerings and use common, uniform requisition forms that emphasize physician choice. The format should encourage doctors to order, to the extent possible, only those tests that they believe are appropriate for each patient. In addition, the requisition forms should require physicians to document the need for each test ordered by inserting diagnosis codes to support test. With respect to chemistry tests, requisition forms should be designed to require physicians to order such tests individually (i.e., separately) unless: (1) the test is part of a CPT-defined "clinically relevant test grouping" such as an organ or disease panel or profile (e.g.,-80049-80099); or (2) the test is part of a profile that has been customized at the request of the physician. In addition, a printed statement should appear on every requisition form reiterating that when ordering tests for which Medicare reimbursement will be sought, physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of a patient, rather than for screening purposes.

AH has designed a model requisition form ("AH Model Requisition Form") that should be used by all AH-affiliated laboratories for non-customized test offerings. The AH Model Requisition Form is attached hereto as Exhibit 1.

Any deviations from the AH Model Requisition Form should be reviewed by the facility compliance officer or compliance committee to ensure compliance with the above-stated requirements. In addition, customized requisition forms should also be pre-approved by the facility compliance officer or compliance committee prior to use.

The AH Model Requisition Form shall be reviewed on a periodic basis by appropriate AH representatives to ensure compliance with any changes in the law.

b. Notices to Physicians.

Each AH-affiliated laboratory should provide its clients with annual written notices that set forth: (1) the Medicare medical necessity policy; (2) the individual components of every laboratory profile that includes a multi-channel chemistry test or other automated multiple test result; (3) the CPT or HCPCS codes that the laboratory uses to bill the Medicare program for each such profile; (4) the Medicare National Limitation Amount for each CPT or HCPCS code used to bill Medicare for each profile and its components; (5) a description of how the laboratory will bill Medicare for each profile; and (6) if the laboratory engages a physician clinical consultant, the notice should provide the phone number of the physician clinical consultant and advise of his or her availability to discuss appropriate testing and test ordering. A sample physician notice is attached hereto as Exhibit 2. Copies of each such notice should be retained by the laboratory in accordance with AH's document retention guidelines. Upon the expiration of the retention period for any such notice, such records should be destroyed by the laboratory.

In addition to the general notices described above, AH-affiliated laboratories offering clients the opportunity to create customized profiles should provide all clients who request customized profiles with annual notices that: (1) explain the Medicare reimbursement paid for each component of

each such profile; (2) encourage physicians who are ordering tests for which Medicare reimbursement will be sought to order only tests that are medically necessary for each patient; (3) inform physicians that using a customized profile may result in the ordering of tests for which Medicare may deny payment; (4) inform physicians that the Office of Inspector General (“OIG”), of the Department of Health and Human Services (“HHS”) takes the position that a physician who orders medically unnecessary tests for which Medicare reimbursement is claimed may be subject to civil penalties; and (5) if the laboratory engages a physician clinical consultant, the notice also should provide the phone number of the physician clinical consultant and advise of his or her availability to discuss appropriate testing and test ordering. A sample physician customized profile notice is attached hereto as Exhibit 3. Copies of each such notice should be retained by the laboratory in accordance with AH’s document retention guidelines. Upon the expiration of the retention period for any such notice, such records should be destroyed by the laboratory.

c. Physician Acknowledgments.

AH-affiliated laboratories that agree to customize profiles or requisition forms in response to physician requests should require any such requesting physician to sign a physician acknowledgment substantially in the form attached hereto as Exhibit 4.

d. Test Utilization Monitoring.

AH-affiliated laboratories should implement a test utilization monitoring process to help prevent potential fraud and abuse. The test utilization monitoring process shall require each laboratory to retain and analyze test utilization data from year to year, by CPT or HCPCS code, for the top 30 tests the laboratory performs for Medicare beneficiaries. Each laboratory would then need to compute the percentage growth in claims submitted for each of the top 30 tests from one year to the next. If a test's utilization grew more than 10 percent, the laboratory should contact the facility compliance officer immediately. The facility compliance officer will coordinate with laboratory personnel to undertake an investigation to ascertain the cause of such growth.

After the facility compliance officer has completed his/her investigation, a written report shall be issued to the Corporate Compliance Officer, detailing the factual findings and conclusions of the investigation. If it is determined that the increase in test utilization occurred for a benign reason, then the rationale for the determination should be set forth in a written report and the laboratory need not take any further action. The written report should be retained in accordance with AH’s document retention guidelines. Upon the expiration of the retention period for any such notice, such documents should be destroyed.

In the event AH determines that the increase in utilization was caused by the use of basic chemistry profiles or some other affirmative action on the part of the laboratory, AH will coordinate with legal counsel and take immediate action to ensure that no prohibited activity is being committed by the laboratory in question.

Additionally, if an AH-affiliated laboratory ever has reason to believe that its clients are ordering medically unnecessary tests (other than as discussed in Section 3b, below), such information should be reported immediately to the facility compliance officer.²

3. Billing

a. Billing Policies.

Each AH-affiliated laboratory should ensure that all claims for testing services submitted to Medicare or other federally funded health care programs are accurate and correctly identify the services ordered by the physician (or other individual authorized by law to order tests) and performed by the laboratory.

Selection of CPT or HCPCS Codes.

Each AH-affiliated laboratory should ensure that the CPT or HCPCS code that is used to bill Medicare or other federally funded programs most accurately describes the service that was ordered and performed.

Additionally, each AH-affiliated laboratory should require that its CPT/HCPCS codes are reviewed by individuals (or a committee) with medical and technical expertise in laboratory testing before such codes are approved for claims submissions.³ Laboratory personnel should (i) immediately report any actual or suspected coding abuse,⁴ including any potential “up-coding” and (ii) be encouraged to ask the facility compliance officer questions regarding code selection. Additionally, a laboratory may direct coding questions to (i) its Medicare carrier or intermediary and (ii) the CPT Coding Clearinghouse Service. Any instructions received from the Medicare carrier/fiscal intermediary or the CPT Coding Clearinghouse should be documented in a memorandum. Any such memoranda should be retained by the laboratory. In some cases, it may be appropriate to follow up any conversations with a confirming letter. In such case, the laboratory should keep a copy of the confirming letter for its records.

Selection of ICD-9CM Codes.

Each AH-affiliated laboratory should ensure that it only submits diagnostic information obtained from the test-ordering physician. Specifically, the laboratory should: (1) contact the ordering physician to obtain diagnostic information in the event that the physician has failed to provide such information; (2) provide services and diagnostic information supplied pursuant to a standing order executed in connection with an extended course of treatment; and (3) accurately translate narrative

² Such reports may also be made verbally to the supervisor, department director, local facility compliance officer for that agency, the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities’ compliance officer. Please clearly indicate on the report if anonymity is desired.

³ Individuals involved in this process should not be exclusively billing or financial personnel.

⁴ Such reports may be made verbally to the supervisor, department director, local facility compliance officer for that agency, the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities’ compliance officer. Please clearly indicate on the report if anonymity is desired.

diagnoses obtained from the physician to ICD-9CM codes. Where diagnostic information is obtained from a physician or the physician's staff after receipt of the specimen and the requisition form, documentation of the receipt of such information should be created and maintained. Such documentation should be retained by the laboratory in accordance with AH's document retention guidelines. Upon the expiration of the retention period for any such notice, such documents should be destroyed by the laboratory.

AH-affiliated laboratories are prohibited from: (1) using diagnostic information provided by the physician from earlier dates of service (other than standing orders, as discussed below); (2) using "cheat sheets" that provide diagnostic information that has triggered reimbursement in the past; (3) using computer programs that automatically insert diagnosis codes without receipt of diagnostic information from the physician; or (4) making up diagnostic information for claim's submission purposes. Any person aware of any such activity at any AH-affiliated laboratory should immediately notify the facility compliance officer.⁵

Tests Covered by Claims for Reimbursement.

Each AH-affiliated laboratory should ensure that it only submits claims for tests that were both ordered and performed. If a laboratory receives a specimen without a test order or with an ambiguous test order that is subject to multiple interpretations, the laboratory must check with the doctor to determine what tests he or she wanted performed before submitting a claim for reimbursement to any federally funded program. The laboratory should not perform any laboratory services until a written requisition form is obtained from the ordering physician's office.

Additionally, if a laboratory cannot perform an ordered test for any reason (e.g., a laboratory accident or insufficient quantities of specimen), the laboratory should not submit a claim to any federally funded program (see Section J, below).

Any person aware of AH-affiliated laboratory personnel not complying with these requirements should immediately notify the facility compliance officer.⁶

Billing of Automated Multi-channel Chemistry Tests.

Each AH-affiliated laboratory should ensure that it bills Medicare appropriately for automated multi-channel chemistry tests. AH-affiliated laboratories should bill the HCFA approved organ or disease oriented panels in accordance with the appropriate Medicare Intermediaries' most recent billing instructions.

⁵ Such reports may also be made verbally to the supervisor, department director, local facility compliance officer, the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities' compliance officer. Please clearly indicate on the report if anonymity is desired.

Billing of Calculations.

AH-affiliated laboratories are prohibited from billing for both calculations/hematology indices (e.g., calculated LDLs, T7s, indices) and the tests that are performed to derive such calculations.

Suspect Billing Consultant Arrangements.

The OIG has recently issued a fraud alert describing as suspect any contract between a laboratory and a Medicare billing consultant whereby the billing consultant undertakes to maximize revenues for the laboratory in exchange for a commission based upon the amount of resulting gains for the laboratory. Accordingly, AH-affiliated laboratories should not enter into these types of arrangements.

b. Advance Beneficiary Notice.

(1) Medicare law prohibits providers from billing a beneficiary for a denied claim unless the beneficiary had been notified, prior to the service, that the claim may be denied. As such, in the event Medicare denies payment for AH-AFFILIATED laboratory services, no AH-affiliated laboratory may bill a beneficiary unless the beneficiary received the required notice in the form of an Advance Beneficiary Notice (“ABN”), as described herein.⁷

(2) Except as discussed herein, each ABN must be patient- and test-specific, informing the patient before the test is performed of the reason(s) why Medicare is likely to deny payment. Every ABN, however, must contain each of the following elements:

- (a) the ABN must state that the patient has been informed of the likely claim denial;
- (b) the ABN must state that, in the event of a claim denial, the patient agrees to be financially liable for the laboratory services; and
- (c) the ABN must be signed and dated by the beneficiary.

(3) As noted above, ABNs generally may not be routinely or automatically requested. However, an ABN may routinely be obtained in each of the following cases:

- (a) where a procedure is subject to frequency limits by statute (e.g., pap smears and screening mammography) or by local carrier policy (e.g., glucose);

⁷ As necessary, the physician should obtain one ABN per test ordered.

- and
- (b) where the procedure is for non-FDA approved tests;
 - (c) when it is known that the procedure will not be covered for the reported condition.

Each of these types of tests are included on the AH Model ABN attached hereto as Exhibit 5 (Option 1). The Model ABN may be used only in the limited circumstances described above. If the test ordered does not fall within one of the three exceptions, a patient- and test-specific ABN must be used (see Exhibit 5; Option 2).

(4) After obtaining an ABN (where appropriate) and performing the test, the claim should be submitted to the intermediary since the beneficiary has a right to a Medicare determination. Each laboratory must use the modifier “GA” on the claim, which indicates that the laboratory has obtained a properly executed ABN.⁸

(5) The beneficiary has the right to refuse to execute an ABN. In such event, two witnesses should attest in writing that the beneficiary was so informed in advance of why Medicare was likely to deny payment.

(6) If the beneficiary is mentally incompetent, the ABN should be signed by a person who normally handles the beneficiary’s affairs.

(7) Where a potentially denied service will be requested over a specified time frame (such as an extended course of treatment), one ABN will generally suffice for that period as long as no new services are added and the reason for the likely claim denial does not change.

(8) Each laboratory should educate all appropriate laboratory personnel regarding these ABN policies.

(9) If the Medicare claim is denied and a proper ABN (or attestation) is on file, the laboratory may bill the beneficiary. The beneficiary should be charged the same amount as that submitted on the Medicare claim.

(10) Each AH-affiliated laboratory that refers tests to reference laboratories should implement the above policies to ensure that ABNs are on file for any tests referred to the reference laboratory (since the reference lab may hold the

⁸ Additionally, when using the HCFA-1500, include the following statement in the narrative/procedure description field (Block 24D): “We have given the beneficiary proper advance notice of the likelihood of Medicare denial of payment.”

referring laboratory financially responsible in the event the claim is denied and there is no filed ABN).

(11) **Each AH-affiliated laboratory should communicate these ABN policies to its referring providers to ensure that such providers properly obtain ABNs in connection with the tests referred to the AH-affiliated laboratory.**

(12) **Each AH-affiliated laboratory should develop a record retention policy to maintain (i) the executed ABNs and (ii) attestations (if applicable) in accordance with the AH record retention policy after the submission of the claim in question. Upon the expiration of the retention period of the claim in question, such documentation should be destroyed by the laboratory.**

(13) **AH-affiliated laboratories should not do or encourage referring providers to do any of the following:**

- (a) obtain an ABN after Medicare has denied payment for a submitted claim; or
- (b) have all Medicare patients automatically sign an ABN for services provided.

4. Reliance on Standing Orders

Each AH-affiliated laboratory must contact all nursing homes from which the laboratory has received standing orders and request that the nursing homes confirm in writing the validity of all current standing orders. Such written confirmation should be retained by the laboratory in accordance with AH's document retention guidelines after the date on which the claims in question were submitted to the federally funded health care program. Upon the expiration of the retention period of the claim's submission, such documents should be destroyed by the laboratory.

In addition, AH-affiliated laboratories should verify standing orders relied upon at draw stations with the physician, physician's office staff, or such other persons authorized by law to order tests, who have provided the standing orders to the laboratory. Such verification should be obtained six (6) months from the date of the standing order, should be in writing and should be retained by the laboratory in accordance with AH's document retention guidelines after the date on which the claims in question were submitted to the federally funded health care program. Upon the expiration of the retention period of the claim's submission to the applicable federally funded health care program, such documentation should be destroyed by the laboratory.

Finally, with respect to end stage renal disease ("ESRD") patients, at least once every six (6) months, AH-affiliated laboratories should contact each ESRD facility or unit to request confirmation in writing of the continued validity of all existing standing orders. Such confirmation should be retained by the laboratory in accordance with AH's document retention guidelines after the date on

which the claims in questions were submitted to the federally funded health care program. Upon the expiration of the retention period of the claim's submission to the applicable federally funded health care program, such documentation should be destroyed by the laboratory.

5. Compliance with Applicable HHS OIG Fraud Alerts

Each AH-affiliated laboratory should comply with the requirements of fraud alerts that are issued by the government from time to time. AH compliance officers will disseminate applicable fraud alert requirements in the most effective and efficient manner to each AH-affiliated laboratory. In addition, the actual fraud alert shall be forwarded to each AH-affiliated laboratory by the facility compliance officer. Such material should be readily accessible to laboratory personnel. Any questions regarding compliance with fraud alert requirements should be directed to the facility compliance officer.

6. Marketing

AH-affiliated laboratories shall continue to require honest, straightforward, fully informative and non-deceptive marketing. All personnel connected with marketing shall receive training and education at least annually which shall focus on sales activities prohibited by federal and state law, including, the offering of anything of value in return for referral of business.

7. Prices Charged Physicians for Profiles

AH-affiliated laboratories should ensure that as tests are included in or added to profiles, the price for the enhanced profile increases and the overall price for the profile is never below cost. Such policies are designed to avoid any claim of possibly suspect conduct under the anti-kickback statute.

8. Retention of Records

Generally, laboratory records should be maintained in accordance with AH's document retention guidelines after submission of the claim in question to the federally funded health care program. Upon the expiration of the retention period of the claim's submission to the applicable federally funded health care program, such documentation (i.e., the claims and patient records⁹) should be destroyed by the laboratory.

a. All AH-affiliated laboratories must comply with applicable federal law and AH policies with respect to retention of laboratory records. Such requirements are set forth on Exhibit 6; each AH-affiliated laboratory, however, is responsible for identifying and complying with any and all changes or amendments to such requirements that may occur after the effective date of this Program.

⁹ AH-affiliated laboratories must retain certain patient records for longer periods of time. For example, records for patients who are minors generally should be kept for a twenty-five (25) year period.

b. AH-affiliated laboratories located in **California** must comply with applicable state law and AH policies with respect to retention of laboratory records. Such requirements are set forth on Exhibit 7; each California AH-affiliated laboratory, however, is responsible for identifying and complying with any and all changes or amendments to such requirements that may occur after the effective date of this Program.

c. AH-affiliated laboratories **located in Hawaii** must comply with applicable state law and AH policies with respect to retention of laboratory records. Such requirements are set forth on Exhibit 8; each Hawaii AH-affiliated laboratory, however, is responsible for identifying and complying with any and all changes or amendments to such requirements that may occur after the effective date of this Program.

d. AH-affiliated laboratories located in **Oregon** must comply with applicable state law and AH policies with respect to retention of laboratory records. Such requirements are set forth on Exhibit 9; each Oregon AH-affiliated laboratory, however, is responsible for identifying and complying with any and all changes or amendments to such requirements that may occur after the effective date of this Program.

e. AH-affiliated laboratories located in **Washington** must comply with applicable state law and AH policies with respect to retention of laboratory records. Such requirements are set forth on Exhibit 10; each Washington AH-affiliated laboratory, however, is responsible for identifying and complying with any and all changes or amendments to such requirements that may occur after the effective date of this Program.

f. All AH-affiliated laboratory facilities must retain laboratory records for the longest applicable period for any of the above retention policies.

9. Employees

a. Each person involved in the sale, marketing, or billing of laboratory services, and all phlebotomists, should (1) receive and review those Laboratory Compliance Program policies applicable to each person's job performance; (2) discuss with his/her supervisor or the supervisor's designee the standards of conduct required under such policies; and (3) sign an acknowledgment that he/she has complied with (1) and (2) herein and will abide by such policies.¹⁰ New employees involved in the sale, marketing, or billing of laboratory services, and all new phlebotomists, should also fulfill these requirements.

b. Each AH-affiliated laboratory shall post in common work areas a notice that details AH's commitment to comply with applicable federal and state law in the conduct of its laboratory business. The notice shall be substantially in the form as Exhibit 8 hereto.

¹⁰ See Attachment 2 of the Legal Compliance Program for a sample employee acknowledgment form.

B. Self-Referral Laws

Certain federal and state laws prohibit laboratories from submitting claims for a service where the service was referred to the laboratory by a physician who has a financial relationship with the laboratory (or where certain family members of the referring physician have financial arrangements with the laboratory).

Accordingly, where a referring physician (or a family member of a referring physician) has a financial arrangement (including a compensation and ownership/investment interest) with an AH-affiliated entity, the facility compliance officer should be notified to ensure that any such arrangement meets an exception to the applicable self-referral law. The facility compliance officer should coordinate with legal counsel during this review process.

C. Anti-Kickback

Certain federal and state laws prohibit health care providers from paying for referrals. Each AH-affiliated laboratory should ensure that the laboratory is not paying for referrals. Accordingly, no laboratory may (1) offer discounts or anything of value to physicians/other referral sources in order to induce the referral of lab tests; (2) provide or offer to provide laboratory services for free or at rates below the lab's costs for such services in order to obtain referrals; (3) offer or provide free pick-up and disposal of bio-hazardous wastes (such as sharps) unrelated to the collection of specimens for an outside lab; (4) provide computers, fax machines or other equipment to referring health care providers, unless however, such equipment is used exclusively for the performance of the outside lab's work; (5) provide free lab testing for referring professionals, their families and/or employees; and (6) provide the services of a phlebotomist to a referral source unless (i) the phlebotomist only provides laboratory-related services such as collection/processing of lab specimens and (ii) there is a written contract between the health care provider and the AH-affiliated laboratory which prohibits the phlebotomist from performing non-laboratory related services.¹¹

D. CLIA

Each AH-affiliated laboratory should ensure compliance with applicable CLIA requirements or state law requirements¹², including, (1) obtaining and maintaining the appropriate CLIA certificate based on the types of tests performed by the laboratory;¹³ (2) ensuring that each laboratory is

¹¹ However, see Section L1, below (labs operating in California may not place their phlebotomists in physician offices under California state law).

¹² Washington and Oregon are exempt from the conditions of participation requirements of CLIA.

¹³ Please note that in some cases CLIA may require a separate CLIA certificate for a lab located in a different part of a hospital than the main hospital lab. In such case, both labs should obtain the applicable CLIA certificate.

under the overall management of a qualified laboratory director;¹⁴ (3) implementing the applicable proficiency testing program; (4) implementing the applicable patient test management system; (5) implementing the applicable quality control program; and (6) implementing the applicable quality assurance program.

E. Rural Health Clinics (RHC) & Hospices

Certain testing services for patients of RHCs and hospices are reimbursed through payment of an all-inclusive rate to the RHC/hospice for each beneficiary visit. As such, AH-affiliated laboratories that perform tests for RHC/hospice Medicare beneficiaries that are subject to the all-inclusive rate may not bill the Medicare program for such services. Instead, the RHC/hospice should be billed by the laboratory. Each laboratory should identify tests subject to the all-inclusive rate and ensure that the laboratory does not bill the Medicare program for such services.

F. ESRD

Certain testing services for patients of ESRD (e.g., composite rate or routine tests) cannot be billed separately to Medicare Part B, but rather must be purchased by the ESRD clinic itself. Each laboratory should identify tests subject to the composite rate classification and ensure that the laboratory does not bill the Medicare program for such services. Instead, the laboratory should bill the ESRD clinic (at a commercially reasonable price) for the composite rate tests ordered for its patients.

G. Billing of Lab Tests for Hospitalized Inpatients

As a general rule, Medicare Part A may not be separately billed for laboratory tests performed for hospitalized inpatients, regardless of what type of lab conducts the tests. Instead, reimbursement for the laboratory tests is bundled into the DRG payment to the hospital under Medicare's prospective payment system. As such, AH-affiliated laboratories should not bill Medicare separately for tests performed for hospitalized Medicare patients.¹⁵

H. Proper Handling of Preadmission Testing Services

Laboratory tests performed for Medicare beneficiaries by AH hospital labs or by labs owned and operated by AH hospitals within the 72-hour time period preceding admission may not be separately billed to Medicare.

¹⁴ The laboratory director must be a licensed physician and must be qualified to manage and direct the laboratory personnel. In addition, federal law prohibits a laboratory director from directing more than 5 laboratories (however, under California law, the laboratory director may not direct more than 3 laboratories).

¹⁵ If the AH laboratory is acting as a reference lab, it may look to the hospital for payment for its services.

I. Direct Billing Requirements

Except as otherwise provided in this Compliance Program, AH-affiliated laboratories should bill Medicare directly.

J. Follow-Up, Repeated Tests

AH-affiliated laboratories should not bill follow-up, repeated tests. Instead, each lab should not bill Medicare in the first instance for any test for which the specimen deteriorated, the specimen quantity was inadequate, the test was performed on the wrong specimen or an incorrect test was performed. If the test-ordering professional determines, after learning of the problem, that the test he/she ordered continues to be medically necessary, the lab may perform that test and bill Medicare.

K. Billing for Tests Ordered on Same Requisition

Where a test-ordering professional orders duplicative tests, the lab should not bill Medicare twice, except, however, where a test is ordered twice to be performed twice (e.g., use of tumor markers or when medically necessary).

L. Compliance with State Law

1. AH-affiliated laboratories located in California

a. Phlebotomists: Laboratories should not place their phlebotomists in physician offices and the offices of medical groups that are not outpatient clinics owned and operated by the AH-affiliated hospital. Phlebotomists may, however, be placed in skilled nursing facilities and weight loss centers.

b. Anti-Mark Up: Laboratories billing for services rendered by another provider should not charge any amounts in excess of that charged by the performing laboratory. In addition, certain disclosure requirements must be satisfied if the non-performing provider bills for the laboratory services. As such, no laboratory may bill for lab services performed by another lab unless such arrangement is pre-approved by the facility compliance officer in consultation with legal counsel.¹⁶

¹⁶ Pursuant to revised Hospital Manual Section 437 (Billing for Clinical Diagnostic Laboratory Services Other Than Inpatient), when a hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the referring hospital (i.e., the original hospital) may bill for the arranged lab services. Each AH-affiliated laboratory should comply with this billing requirement but should consult with the facility compliance officer to ensure that any such arrangement is in compliance with applicable state law.

- c. Persons authorized to Order Tests: Laboratories may only accept assignment for tests and only make reports to persons licensed under California healing arts provisions or their representatives.
- d. Clinical Laboratory License: Each laboratory must maintain the appropriate license under California law (see California Business & Professions Code Section 1265).
- e. Certification under Medicare: Each laboratory must be certified or meet the requirements for certification under Title XVIII of the Federal Social Security Act and have elected to provide services under Title XVIII.
- f. Participation in State-Approved Proficiency Testing Program: Each laboratory must participate in the applicable state-approved proficiency testing program.
- g. Equipment and Facilities: Each laboratory must maintain equipment and facilities that are adequate and appropriate for the services rendered at the lab.
- h. Proficiency Testing/Release of Test Results: Each laboratory performing tests other than waived tests must enroll and demonstrate successful participation, as defined in CLIA, for each specialty and subspecialty in which it performs clinical laboratory tests, to the same extent as required by CLIA. Each laboratory must report such test results to the Department of Health Services in an electronic format that is compatible with the Department's proficiency data monitoring system and authorize the release of such data to the public to the same extent required by CLIA.
- i. Patient Test Management System: Each laboratory performing tests other than waived tests must establish a patient test management system that meets the requirements of CLIA.
- j. Quality Control Program: Each laboratory performing tests other than waived tests must establish a quality control program that meets the requirements of CLIA.
- k. Quality Assurance Program: Each laboratory performing tests other than waived tests must establish a quality assurance program that meets the requirements of CLIA.
- l. Posting of Licenses: The license of each person performing tests must be posted conspicuously in the laboratory.
- m. Medi-Cal Usual Price Rules: California regulations prohibit (i) a laboratory from charging Medi-Cal more than the usual charge it bills to the general public and (ii) a laboratory from billing Medi-Cal more than it bills purchasers of comparable services under

comparable circumstances.¹⁷ AH-affiliated laboratories should comply with these rules with respect to their prices charged to Medi-Cal for laboratory services.

2. AH-affiliated laboratories located in Oregon

a. Anti-Mark Up: Laboratories billing for services rendered by another provider should not charge any amounts in excess of that charged by the performing laboratory. In addition, certain disclosure requirements must be satisfied if the non-performing provider bills for the laboratory services. As such, no laboratory may bill for lab services performed by another lab unless such arrangement is pre-approved by the facility compliance officer in consultation with legal counsel.¹⁸

b. Persons authorized to Order Tests: Laboratories may only accept assignment for tests and only make reports to physicians, dentists, or other persons authorized by Oregon law to employ the results thereof in the conduct of a practice or in the fulfillment of official duties, or their agents.

c. Clinical Laboratory License: Each laboratory must maintain the appropriate license under Oregon law (see Oregon Revised Statutes Section 438.110).

d. Certification under Medicare: Each laboratory must be certified or meet the requirements for certification under Title XVIII of the Federal Social Security Act and have elected to provide services under Title XVIII.

e. Participation in State-Approved Proficiency Testing Program: Each laboratory must participate in the applicable state-approved proficiency testing program.

f. Equipment and Facilities: Each laboratory must maintain equipment and facilities that are adequate and appropriate for the services rendered at the lab and shall meet the requirements of Oregon Administrative Rules (“OAR”) 333-24-026.

g. Proficiency Testing/Release of Test Results: Each laboratory performing tests other than waived tests must enroll and demonstrate successful participation, as defined in OAR 333-24-040, for each specialty and subspecialty in which it performs clinical laboratory tests, to the same extent as required by CLIA. Each laboratory must report such test results to

¹⁷ California courts have held that provider-type clients, such as hospitals and other institutions, constitute the general public and are purchasers comparable to Medi-Cal for purposes of these regulations.

¹⁸ Pursuant to revised Hospital Manual Section 437 (Billing for Clinical Diagnostic Laboratory Services Other Than Inpatient), when a hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the referring hospital (i.e., the original hospital) may bill for the arranged lab services. Each AH-affiliated laboratory should comply with this billing requirement but should consult with the facility compliance officer to ensure that any such arrangement is in compliance with applicable state law.

the Division's proficiency data monitoring system and authorize the release of such data to the public to the same extent required by CLIA.

h. Patient Test Management System: Each laboratory performing tests other than waived tests must establish a patient test management system that meets the requirements of CLIA.

i. Quality Control Program: Each laboratory performing tests other than waived tests must establish a quality control program that meets the requirements of OAR 333-24-035 and OAR 333-24-040.

j. Quality Assurance Program: Each laboratory performing tests other than waived tests must establish a quality assurance program that meets the requirements of OAR 333-24-035.

k. Posting of Licenses: The license issued to the owner of the laboratory must be posted conspicuously in the laboratory.

l. Medicaid Usual Price Rules: Oregon regulations prohibit (i) a laboratory from charging Medicaid more than the lower of charges it bills to the majority of non-Medicaid users of the same service based on the preceding month's charges or (ii) its lowest charge per test on the same date that is advertised, quoted or posted. AH-affiliated laboratories should comply with these rules with respect to their prices charged to Medicaid for laboratory services.

3. AH-affiliated laboratories located in Washington

a. Anti-Mark Up: Laboratories billing for services rendered by another provider should not charge any amounts in excess of that charged by the performing laboratory. In addition, certain disclosure requirements must be satisfied if the non-performing provider bills for the laboratory services. As such, no laboratory may bill for lab services performed by another lab unless such arrangement is pre-approved by the facility compliance officer in consultation with legal counsel.¹⁹

b. Persons authorized to Order Tests: Laboratories may only accept assignment for tests and only make reports to persons authorized to order such tests and receive reports under Washington law or rules, or their representatives.

¹⁹ Pursuant to revised Hospital Manual Section 437 (Billing for Clinical Diagnostic Laboratory Services Other Than Inpatient), when a hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the referring hospital (i.e., the original hospital) may bill for the arranged lab services. Each AH-affiliated laboratory should comply with this billing requirement but should consult with the facility compliance officer to ensure that any such arrangement is in compliance with applicable state law.

c. Clinical Laboratory License: Each laboratory must maintain the appropriate license under Washington law (see Revised Code of Washington (“RCW”) Section 70.42 *et seq.*; Washington Administrative Code (“WAC”) Chapter 246-338-20).

d. Certification under Medicare: Each laboratory must be certified or meet the requirements for certification under Title XVIII of the Federal Social Security Act and have elected to provide services under Title XVIII.

e. Participation in State-Approved Proficiency Testing Program: Each laboratory must participate in the applicable state-approved proficiency testing program unless granted a certificate of waiver.

f. Equipment and Facilities: Each laboratory must maintain equipment and facilities that are adequate and appropriate for the services rendered at the lab.

g. Proficiency Testing/Release of Test Results: Each laboratory performing tests other than waived tests must enroll and demonstrate successful participation, as defined in WAC 246-338-050 and, for each specialty and subspecialty in which it performs clinical laboratory tests, to the same extent as required by CLIA. Each laboratory must report such test results to the Department of Health in an electronic format that is compatible with the Department’s proficiency data monitoring system and authorize the release of such data to the public to the same extent required by CLIA.

h. Patient Test Management System: Each laboratory performing tests other than waived tests must establish a patient test management system that meets the requirements of CLIA.

i. Quality Control Program: Each laboratory performing tests other than waived tests must establish a quality control program that meets the requirements of WAC 246-338-090.

j. Quality Assurance Program: Each laboratory performing tests other than waived tests must establish a quality assurance program that meets the requirements of CLIA and WAC 246-338-080.

k. Medicaid Usual Price Rules: Washington regulations require laboratories to bill the Department of Social and Health Services according to rates it establishes. AH-affiliated laboratories should comply with these rules with respect to their prices charged to Medicaid for laboratory services.

4. AH-affiliated laboratories located in Hawaii

a. Phlebotomists: If a phlebotomist is placed in a physician's office and performs tasks normally the responsibility of the physician's office staff, then it may be characterized as a kickback or prohibited financial relationship. Consequently, laboratories

should not place their phlebotomists in physician offices and the offices of medical groups that are not outpatient clinics owned and operated by the AH-affiliated hospital. Phlebotomists may be placed in skilled nursing facilities and weight loss centers, but they may not perform duties that are normally the responsibility of the facility's or center's staff.

b. No Mark Up: Laboratories billing for services rendered by another provider are generally prohibited from "marking up" the charges. In other words, the laboratory may not charge more than what the laboratory that performed the test charges. As such, a laboratory may not bill for lab services performed by another lab unless such arrangement is pre-approved by the facility compliance officer in consultation with legal counsel.²⁰

c. Persons authorized to Order Tests: Laboratories may only accept assignment for tests and only make reports to persons authorized to use the findings of laboratory examinations in his or her practice.

d. Clinical Laboratory License: Each laboratory must maintain a license under Section 3 of Chapter 30 of the Public Health Regulations of the Department of Health (or any successor statute or regulation).

e. Certification under Medicare: Each laboratory must be certified or meet the requirements for certification under Title XVIII of the Federal Social Security Act and have elected to provide services under Title XVIII.

f. Participation in State-Approved Proficiency Testing Program: Each laboratory must participate in the applicable state-approved proficiency testing program.

g. Equipment and Facilities: Each laboratory must maintain equipment and facilities that are adequate and appropriate for the services rendered at the lab.

h. Proficiency Testing/Release of Test Results: Each laboratory performing tests other than waived tests must enroll and demonstrate successful participation, as defined in CLIA, for each specialty and subspecialty in which it performs clinical laboratory tests, to the same extent as required by CLIA.

i. Posting of Licenses: The license of the facility and each person performing tests must be posted in a prominent place in the laboratory.

²⁰ Pursuant to revised Hospital Manual Section 437 (Billing for Clinical Diagnostic Laboratory Services Other Than Inpatient), when a hospital obtains laboratory tests for outpatients under arrangements with clinical laboratories or other hospital laboratories, only the referring hospital (i.e., the original hospital) may bill for the arranged lab services. Each AH-affiliated laboratory should comply with this billing requirement but should consult with the facility compliance officer to ensure that any such arrangement is in compliance with applicable state law.

j. Medicaid Usual Price: AH-affiliated laboratories should not charge Medicaid more than the usual charge it bills to the general public or more than it bills purchasers of comparable services under comparable circumstances.

M. Specimen Collection Fees

a. AH-affiliated laboratories should ensure by policy and procedure that only one specimen fee is charged per each type of specimen collected per encounter.²¹ Additionally, AH-affiliated labs may only bill collection fees for specimens extracted by its personnel.

b. AH-affiliated labs should not charge specimen fees for any patient dialyzed in an ESRD facility or any patient dialyzed at home under reimbursement Method I;

c. AH-affiliated labs in California, should not bill for routine handling charges where a specimen is referred to an outside lab or where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time).

d. AH-affiliated laboratories in Oregon may bill for routine handling charges where a specimen is referred to an outside lab or where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time).

e. AH-affiliated laboratories in Washington may bill for routine handling charges where a specimen is referred to an outside lab or where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time).

f. AH-affiliated laboratories in Hawaii may bill for routine handling charges where a specimen is referred to an outside lab or where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time).

N. Miscellaneous

AH-affiliated laboratories should not:

a. participate in schemes that involve collusion between providers and/or suppliers that result in higher charges to Medicare;

b. utilize split billing schemes (e.g., billing procedure over a period of days when all the services were provided on the same day); or

²¹ Note, however, that where a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a *single* encounter and the lab may bill for only *one* collection fee.

c. misrepresent (i) the services supplied by up-coding or use of inappropriate procedure codes; (ii) the amounts charged for the services rendered; (iii) the identity of the person receiving the services; or (iv) the date on which the services were performed.

Exhibit 1

AH MODEL REQUISITION FORM

[Hospital LOGO]

[Address] \v[City], [State] [Zip]
Director

Phone: (619)470-4170

DRAFT

CLINICAL LABORATORY

[Name], MD – Medical Director

[Name], MD – Associate

[Name], MD – Pathologist

[Name], MD – Pathologist

TEST REQUISITION

PLEASE ATTACH A COPY OF ALL INSURANCE I.D. CARDS (Front & Back)

Date Collected	Time Collected	PATIENT'S NAME (Last, First, MI)	SEX	SOCIAL SECURITY NUMBER	D.O.B.	AGE
----------------	----------------	----------------------------------	-----	------------------------	--------	-----

Ordering Physician	FAX RESULTS Fax Number: _____	CALL RESULTS Phone Number: _____	STAT
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COMPLETE FOR ALL BILLING TYPES

COMPLETE FOR ALL THIRD PARTY BILLING

BILL TO: PHYSICIAN PATIENT INSURANCE MEDICARE MEDI-CAL

RESPONSIBLE PARTY	INSURANCE COMPANY
-------------------	-------------------

ADDRESS	ADDRESS
---------	---------

CITY, STATE, ZIP	PHONE NUMBER	CITY, STATE, ZIP	PHONE NUMBER
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If any individual component/test included in a panel is not , in your professional medical opinion, medically necessary for your patient, you must individually order only the test(s) which is(are) medically necessary. Your signature certifies that they are medically necessary. PHYSICIAN SIGNATURE _____ DATE: _____	INSURED I.D. NUMBER	GROUP NUMBER
	MEDICARE / MEDI-CAL NUMBER	<input type="checkbox"/> SIGNED ADVANCED BENEFICIARY NOTICE OBTAINED

TEST NAME	HCPC CODE	ICD - 9	TEST NAME	HCPC CODE	ICD - 9
CMS PANELS (Descriptions on Back of Form)			PSA	84153	
COMPREHENSIVE METABOLIC PANEL	80053		CEA	82378	
BASIC METABOLIC PANEL	80048		SODIUM	84295	
HEPATIC FUNCTION PANEL	80076		IRON BINDING CAPACITY	83550	
ELECTROLYTE PANEL	80051		TOTAL PROTEIN	84155	
LIPID PANEL	80061		TRIGLYCERIDE	84478	
RENAL PANEL	80069		URIC ACID	84550	
ACUTE HEPATITIS PANEL	80074		LDL DIRECT	83721	
OBSTETRIC PANEL	80055		HCG QUANTITATIVE PREGNANCY	84702	
HEMATOLOGY / COAGULATION			GLYCOHEMOGLOBIN A1C	83036	
COMPLETE BLOOD COUNT (CBC)	82025		PHENYTOIN	80185	
HEMOGRAM	85027		THEOPHYLLINE	80198	
SED RATE (Westergren)	85651		VALPROIC ACID	80164	
RETICULOCYTE COUNT	85044		PHENOBARBITOL	80184	
PROTIME	85610		MICROBIOLOGY Source: _____		
APTT	85730		CULTURE, GENITAL*	87070	
CHEMISTRY			CULTURE, STOOL*	87045	
ALBUMIN	82040		CULTURE, THROAT*	87070	
ALKALINE PHOSPHATASE	84075		CULTURE, URINE*	87078	
ALT (SGPT)	84460		CULTURE, AFB (with stain)*	87116	
AST (SGOT)	84450		CULTURE, FUNGAL*	87102	
BILIRUBIN, DIRECT	82248		CULTURE, HERPES	87252	
BILIRUBIN, TOTAL	82247		CULTURE, VIRAL	87252	
BUN	84520		STOOL OCCULT BLOOD	82270	
CALCIUM	82310		OVA & PARASITES	87177	
CHLORIDE	82435		CHLAMYDIA BY LCR	87491	
CHOLESTEROL	82465		GC BY LCR	87590	
CO2	82374		URINALYSIS Source: _____		
CK, TOTAL	82550		URINALYSIS SCREEN	81003	
CREATININE	82565		COMPLETE URINALYSIS WITH MICRO	81001	
FERRITIN	82728		COMPLETE URINALYSIS, CULT IF INDICATED*	81001	
GGT	82977		PREGNANCY, QUALITATIVE (serum/urine)	84703	
GLUCOSE	82947		SEROLOGY		
GLUCOSE TOLERANCE (Duration _____)	82951		MONOSPOT	86308	
GLUCOSE TOLERANCE, 2 hr POST PRANDIAL	82951		RPR	86592	
GLUCOSE TOLERANCE, GESTATIONAL	82951		RUBELLA	86762	
HDL	83718		RHEUMATOID FACTOR	86430	
IRON	83540		HIV	86701	
LDH	83615		HEPATITIS B SURFACE ANTIGEN	87340	

MAGNESIUM	83735		HEPATITIS B SURFACE ANTIBODY	86706
PHOSPHOROUS	84100		HEPATITIS B CORE ANTIBODY	86704
POTASSIUM	84132		HEPATITIS A ANTIBODY	86708
LH	83002		HEPATITIS C ANTIBODY	86803
FSH	83001		HCV BY PCR QUANTITATIVE	87522
B12	82607		BLOOD BANK	
FOLIC ACID	82746		ABO TYPE	86900
T4	84479		Rh (D)	86906
FREE T4	84439		ANTIBODY SCREEN*	86850
TSH	84443		OTHER:	
			*MAY INCUR ADDITIONAL CHARGES	

Back Page of Requisition

[Hospital Logo]
 [Address, City, State Zip]
 Phone: [(XXX) XXX-XXXX]
 Fax: [(XXX) XXX-XXXX]

Inpatient Hours of Operation: 24 hours per day, 7 days per week
 Specimen Collection Station – Outpatient Pavilion: Monday through Friday, 7:30 am to 4:00 pm

Comprehensive Metabolic Panel (80053)

Albumin (82040)
 Bilirubin, Total (82250)
 Calcium (82310)
 Chloride (82435)
 Creatinine (82565)
 Glucose (82947)
 Alkaline Phosphatase (84075)
 Potassium (84132)
 Total Protein (84155)
 Sodium (84295)
 AST/SGOT (84450)
 BUN (84520)
 ALT/SGPT (84460)

Acute Hepatitis Panel (80074)

Hepatitis B Surface Antigen (87340)
 Hepatitis B Surface Antibody (86706)
 Hepatitis B Core Antibody (86704)
 Hepatitis C Antibody (86803)
 Hepatitis A Antibody (86708)

Hepatic Function Panel (80076)

Albumin (82040)
 Bilirubin, Total (82250)
 Bilirubin, Direct (82248)
 Total Protein (84155)
 Alkaline Phosphatase (84075)
 AST/SGOT (84450)
 ALT/SGPT (84460)

Basic Metabolic Panel (80048)

CO2 (82374)
 Chloride (82435)
 Creatinine (82565)
 Glucose (82947)
 Potassium (84132)
 Sodium (84295)
 BUN (84520)
 Calcium (82310)

Electrolyte Panel (80051)

CO2 (82374)
 Chloride (82435)
 Potassium (84132)
 Sodium (84295)

Lipid Panel (80061)

Cholesterol (82565)
 Triglycerides (84478)
 HDL (83718)
 LDL (calculated)

Renal Panel (80069)

Sodium (84295)
 Potassium (84132)
 Chloride (82435)
 CO2 (82374)
 Glucose (82947)
 BUN (84520)
 Creatinine (82565)
 Calcium (82310)

Obstetric Panel (80055)

CBC (82025)

ABO(86900)

Rh (86906)

Antibody Screen (86850)

Rubella Screen (86762)

Hepatitis B Surface Antigen (87340)

RPR (86592)

Exhibit 2

AH ANNUAL NOTICE TO PHYSICIAN FORM

[Laboratory Letterhead]

VIA CERTIFIED MAIL

[Name of Physician]

[Address of Physician]

Re: Annual Physician Notice

Dear *[Name of Physician]*:

As you are probably aware, the Department of Health and Human Services has issued guidance for compliance with federal law by clinical laboratories in the form of a model laboratory compliance program. In this model plan, the government recommends that each clinical laboratory provide its customers with an annual notice describing each of the following: (i) the Medicare medical necessity policy; (ii) the individual components of every laboratory profile that includes a multi-channel chemistry test or other automated multiple test result; (iii) the CPT or HCPCS codes that the laboratory uses to bill the Medicare program for each such profile; and (iv) the Medicare National Limitation Amount for each CPT or HCPCS code used to bill Medicare for each profile and its components.

In order to comply with the government's recommended notice requirements, we wish to notify you of the following:

Medicare's Medical Necessity Requirement: When you are ordering lab tests for which Medicare reimbursement will be sought, you should only order those tests which, in your professional medical opinion, are medically necessary for that specific Medicare beneficiary. Additionally, please be aware that the government takes the position that a physician who orders medically unnecessary tests may be subject to civil penalties.

Profile Information: Attached as Attachment 1 hereto is a description of each profile offered on our standard requisition form. Also detailed on Attachment 1 is the following information: (a) the individual components of every laboratory profile that includes a multi-channel chemistry test or other automated multiple test result; (b) the CPT or HCPCS codes that we use to bill the Medicare program for each such profile; and (c) the Medicare National Limitation Amount for each CPT or HCPCS code used to bill Medicare for each profile and its components.

Please review the information included on Attachment 1 and contact [add name of appropriate lab personnel] [{"insert clinical consultant's name}], our facility's clinical consultant, who may

be reached at {insert phone number of clinical consultant}, {insert days}, during the hours {insert hours}] with any questions you may have. Thank you.

Sincerely,

Enclosure

Attachment 1

PROFILES

[List Standard Profiles--should list (i) each individual test included in the profile; (ii) the CPT/HCPCS code used to bill Medicare for the profile; and (iii) the National Medicare Limitation Amount for each profile and its component]

<u>Profile</u>	<u>Component Tests</u>	<u>CPT/HCPCS</u>	<u>NMLA (components)</u>	<u>NMLA (profile)</u>
<i>Profile X</i>	<i>ferritin chloride iron</i>			

Our facility bills this profile with CPT/HCPCS code [insert] and receives \$[insert] as payment for this service from Medicare.

Exhibit 3

AH ANNUAL CUSTOMIZED PANEL NOTICE TO PHYSICIAN FORM

[Laboratory Letterhead]

VIA CERTIFIED MAIL

[Name of Physician]

[Address of Physician]

Re: Annual Customized Panel Physician Notice

Dear *[Name of Physician]*:

As you are probably aware, the Department of Health and Human Services has issued guidance for compliance with federal law by clinical laboratories in the form of a model laboratory compliance program. In this model plan, the government recommends that each clinical laboratory provide its customers utilizing customized panels with an annual notice describing each of the following: (i) the Medicare medical necessity policy; and (ii) the Medicare reimbursement paid for each component of the customized profile.

In order to comply with the government's recommended notice requirements, we wish to notify you of the following:

Medicare's Medical Necessity Requirement: When you are ordering lab tests for which Medicare reimbursement will be sought, you should only order those tests which, in your professional medical opinion, are medically necessary for that specific Medicare beneficiary. Additionally, the government believes that the use of a customized profile may, in some cases, result in the ordering of tests for which Medicare or other federally funded health care programs may deny payment. As such, please ensure that you order individual tests or a less inclusive profile when not all of the tests included in the customized profile are medically necessary for the Medicare beneficiary in question. Lastly, please be aware that the government takes the position that a physician who orders medically unnecessary tests may be subject to civil penalties.

Customized Profile Information: Attached as Attachment 1 hereto is a description of each customized profile you have utilized at our lab during the last twelve months. Also detailed on Attachment 1 is the following information: (a) the reimbursement amount that Medicare (and where appropriate, Medicaid) paid for each test included in each customized profile listed on Attachment 1; and (b) the individual components of every laboratory profile.

Please review the information included on Attachment 1 and contact [add name of appropriate lab personnel] [{insert clinical consultant's name}], our facility's clinical consultant, who may

be reached at {insert phone number of clinical consultant}, {insert days}, during the hours {insert hours}] with any questions you may have. Thank you.

Sincerely,

Enclosure

Attachment 1

CUSTOMIZED PROFILES

[List Customized Profiles--should list each individual test included in the profile and Medicare/Medicaid reimbursement amount for each such test]

<u>Profile</u>	<u>Component Tests</u>	<u>Medicare Reimbursement</u>
<i>Profile X</i>	<i>ferritin</i>	<i>\$5</i>
	<i>chloride</i>	<i>\$6</i>
	<i>iron</i>	<i>\$6</i>

Exhibit 4

AH PHYSICIAN ACKNOWLEDGMENT FORM

(for Customized Profiles)

[Laboratory Letterhead]

VIA CERTIFIED MAIL

[Name of Physician]

[Address of Physician]

Re: Requested Customized Profile

Dear *[Name of Physician]*:

We are writing to confirm that you have requested the customized profile(s) described on Attachment 1 hereto.

Please review the profile(s) described on Attachment 1 and confirm each of the following:

- that you have requested the creation of each custom profile listed on Attachment 1;**
- that you have requested each individual test indicated on Attachment 1 to be included in each such profile;**
- that you are aware of the reimbursement amount that Medicare (and where appropriate, Medicaid) will pay for each test included in each customized profile listed on Attachment 1;**
- that you understand that when ordering tests for which Medicare reimbursement will be sought that you should only order those tests which, in your professional medical opinion, are medically necessary for your patient;**
- that you know that using a customized profile may result in the ordering of tests for which Medicare or other federally funded health care programs may deny payment;**
- that you will order individual tests or a less inclusive profile when not all of the tests included in the customized profile are medically necessary for an individual patient;**
- that you are aware that the government takes the position that a physician who orders medically unnecessary tests may be subject to civil penalties; and**
- [Insert clinical consultant's name] is available to assist you in laboratory test selection for your patients. [Insert clinical consultant's name] may be**

reached at [insert phone number of clinical consultant], [insert days], during the hours [insert hours]. Thank you.

* * *

Please sign and date the acknowledgment below and return to me if you agree with the above.

Sincerely,

Enclosure

I hereby acknowledge that the foregoing is accurate and true.

[Add Physician's Name]

Dated

Attachment 1

CUSTOMIZED PROFILES

[List Customized Profiles--should list each individual test included in the profile and Medicare/Medicaid reimbursement amount for each such test]

<u>Profile</u>	<u>Component Tests</u>	<u>Medicare Reimbursement</u>
<i>Profile X</i>	<i>ferritin</i>	<i>\$5</i>
	<i>chloride</i>	<i>\$6</i>
	<i>iron</i>	<i>\$6</i>

Exhibit 5

MODEL ABN

Advance Beneficiary Notice (Option 1)

<p>[Facility Logo]</p> <p>Advance Beneficiary Notice</p>	<p>ORDERING PHYSICIAN INSTRUCTIONS</p> <p>Please complete this form, review with your patient and ask for his/her signature below. Please attach the original with the requisition form and send both items with the patient or specimen. Retain the copy with your records.</p>
<p>Date: _____</p> <p>Requisition #: _____</p> <p>Patient Name: _____</p> <p>Medicare HIC Number: _____</p>	<p>Client #: _____</p> <p>Referring Physician: _____</p>

Medicare will only pay for services that it determines to be “reasonable and necessary” under section 1862(a)(1) of the Medicare law. Your physician is in the best position to know your clinical assessment needs. Occasionally, your physician may order specific tests to help determine a diagnosis or to identify pre-symptomatic diseases. Medicare and other insurers may not pay for such tests.

By signing this form, you acknowledge that you have been notified that Medicare is likely to deny payment for the service(s) indicated below because Medicare usually does not pay (1) for tests ordered for screening purposes, (2) for tests Medicare may not consider medically necessary for your reported condition, or (3) for non-FDA approved tests. If Medicare determines that a particular service, although it would otherwise be covered, is “not reasonable and necessary” under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for:

<p>Please Indicate the Specific Test(s):</p>	
<p>Screening Test(s):</p> <p><input type="checkbox"/> PAP smear (88150, 51, 55, 56, 57) Date of Late Test: _____</p> <p><input type="checkbox"/> PSA (84153)</p> <p><input type="checkbox"/> General Health Panel (80050)</p> <p><input type="checkbox"/> Other _____</p>	<p>Non-FDA Approved Test(s):</p> <p><input type="checkbox"/> Allergen/Rast (86003)</p> <p><input type="checkbox"/> CA 15-3 (86316)</p> <p><input type="checkbox"/> CA 19-9 (86316)</p> <p><input type="checkbox"/> Other _____</p>

Other Expected reason for non-coverage: _____

To be signed by the patient or patient’s legal representative:

I have been notified by my physician that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Patient Signature

Date

Advance Beneficiary Notice (Option 2)

Patient Name _____

Date of Birth _____ Medicare Number _____

Dear Patient:

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment. Please see the listed procedure(s) and possible reason(s) for denial of payment.

Procedure Code _____ Description _____

Explanation (from below) _____ Other _____

Total Charges _____

PATIENT'S AGREEMENT

I have been notified by my doctor that, in my case, Medicare is likely to deny payment for the services identified above, for the denial code or reason listed. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signature _____ Date _____

EXPLANATIONS

According to Medicare guidelines for medically necessary and/or reasonable services and items, Medicare usually does not pay for:

- 1. this procedure because it is not reasonable or necessary under current Medicare guidelines
- 2. screening tests.
- 3. non-FDA approved tests.
- 4. the test indicated above because the federal Medicare carrier has indicated that is not covered for your reported condition.
- 5. *[Add additional explanations for likely denial by Medicare]*

Exhibit 6

FEDERAL LAW/AH RECORD RETENTION REQUIREMENTS

All AH-affiliated laboratories must:

(1) retain records of test requisitions or test authorizations in accordance with AH's document retention guidelines after submission of the claim in question to the federally funded health care program. Upon the expiration of the record retention period, such documentation should be destroyed by the laboratory;

(2) retain the patient's chart or medical record, if used as the test requisition, after submission of the claim in question to the federally funded health care program in accordance with AH's document retention guidelines;

(3) maintain a record system to ensure reliable identification of patient specimens as they are processed and tested to assure that accurate test results are reported. These records must identify the personnel performing the testing procedure. Records of patient testing, including, if applicable, instrument printouts, must be retained for at least two (2) years. Immunohematology records and transfusion records must be retained for no less than five (5) years. In addition, records of blood and blood product testing must be maintained for a period not less than five (5) years after processing records have been completed, or six (6) months after the latest expiration date, whichever is the later date. For pathology, test reports must be retained after the date of reporting, in accordance with AH's document retention guidelines;

(4) send the completed laboratory report promptly to the authorized person, the individual responsible for using the test results or laboratory that initially requested the test;

(5) retain the final report or an exact duplicate of such test report, in electronic or hard copy format, for a period of at least two (2) years after the date of reporting;

(6) ensure by policy and procedures that the results or transcripts of laboratory tests or examinations are released only to authorized persons or the individual responsible for utilizing the test results;

(7) develop and follow written procedures for reporting imminent life-threatening laboratory results or "critical" or "action" values. In addition, the laboratory must immediately alert the individual or entity requesting the test or the individual responsible for utilizing the test results when any test result indicates an imminent life-threatening condition;

(8) ensure that the final report or exact duplicates of test reports, in electronic or hard copy format, are maintained by the laboratory in a manner that permits ready identification and timely accessibility; and

(9) document all individual prices negotiated with clients and retain such documentation after the last claim submitted to the federally-funded program pursuant to such pricing arrangement, in accordance with AH's document retention guidelines. After the expiration of the retention period, all such documents should be destroyed.

Exhibit 7

CALIFORNIA LAW/AH RECORD RETENTION REQUIREMENTS

All California AH-affiliated laboratories must maintain for at least two (2) years the following information:

(1) Records of specimens received and tested, including identification of the patient, name of the submitter, dates of receipt and report, type of test performed, and test results.

(2) Records of inspection, validation, calibration, repair, and replacement to ensure proper maintenance and operation of equipment and proper reactivity of test materials.

(3) Manuals, card files, or flow charts for each procedure performed in the laboratory, including the following information:

(a) Name of procedure.

(b) Source of reference for the test method.

(c) Date director or supervisor last reviewed or modified the procedure.

(d) Current specific instructions for test performance.

(e) Standards and controls required.

(f) Instructions for collecting and handling specimens to ensure test reliability.

(g) Records of quality control procedures in use in the various technical areas of the laboratory, including results on standards and reference materials and action limits when appropriate.

(4) Additional requirements for cytology: The laboratory must retain all cytology slides and cell blocks for at least five (5) years and all cytology reports for at least ten (10) years and records indicating the daily accession of numbered specimens and an appropriate cross-filing system according to patient's name.

Exhibit 8

HAWAII LAW/AH RECORD RETENTION REQUIREMENTS

The State of Hawaii regulates laboratory records generally, and imposes special requirements with respect to blood alcohol, substance abuse testing, and HIV records.

1. Laboratory Records Generally²²

- a. Each clinical laboratory shall retain a duplicate copy of the original report made to the physician or other authorized person of each specimen received for analysis.
- b. Each clinical laboratory shall have a record indicating the daily accession of specimens and shall contain the following information:
 - (1) The laboratory number or other identification of each specimen.
 - (2) The name, the initials or other identification of the person from whom the specimen was taken.
 - (3) The name of the licensed physician or other authorized person or clinical laboratory who submitted the specimen.
 - (4) If the request for the test was oral and not followed by a written confirmation within 48 hours, a statement to that effect.
 - (5) The date, and hour if required, the specimen was collected.
 - (6) The date, and hour if required, the specimen was received in the clinical laboratory.
 - (7) When the specimen is forwarded to another laboratory for tests, the name, the date when the specimen was forwarded to such laboratory, the date it was tested and the date the report of the findings of the tests was received from such laboratory.
 - (8) The condition of unsatisfactory specimens when received (e.g., broken, leaked, hemolyzed or turbid, etc.).
 - (9) The type of test performed.
 - (10) The result of the laboratory test or cross reference to results.
 - (11) The date a report was sent to the Department pursuant to its request.
 - (12) The name, the initials or other identification of the person who performed each test, or, in the case of a test involving performance by more than one person, the name, the initials or other identification of the persons who actually supervised the test on site.
- c. All records and reports of tests performed, including the original or duplicates of original reports from another laboratory, shall be kept on the premises of both laboratories and shall be exhibited to representatives of the Department on request. ***All such records and reports shall be retained for at least five (5) years.***

²² The source of these requirements is Chapter 30 of the Public Health Regulations of the Department of Health.

- d. Each clinical laboratory shall:
 - (1) Maintain current personnel records either in the clinical laboratory or personnel office. These records shall include a resume of the employee's training and experience, including dates of previous and current employment; and
 - (2) Submit lists of clinical laboratory personnel with their technical qualifications to the Department of Health on an annual basis. The Director of Health shall be notified within 90 days of changes in technical personnel.

2. Special requirements for Blood Alcohol, and Substance Abuse, and HIV Testing

a. Alcohol testing²³

- (1) Breath or blood testing for alcohol requires special license.
- (2) Records shall be kept and maintained at the direction of an alcohol testing supervisor.
- (3) Records shall include information on:
 - (i) Each test (blood or breath) conducted;
 - (ii) Accuracy tests for breath alcohol machines,
 - (iii) Maintenance, or repair, or both of instruments used in the testing of blood or other bodily substances for alcohol; and
 - (iv) Results of laboratory performance evaluation programs.

(4) Records shall be retained by the laboratory for at least three years.

b. Substance abuse testing²⁴

- (1) Substance abuse testing requires a special license.
- (2) Before any test result is reported, it must be reviewed and the test certified as accurate by the scientific director.
- (3) The laboratory may transmit results and other information to the medical review officer by various electronic means in a manner designed to ensure confidentiality of the information. Results may not be provided verbally by telephone. The laboratory must ensure the security of the data that is transmitted.

²³ The regulations for blood alcohol testing are at Hawaii Administrative Rules ("H.A.R.") chapter 11-114.

²⁴ The regulations for substance abuse testing are at H.A.R. chapter 11-113.

- (3) *Unless otherwise instructed in writing, all records pertaining to a given specimen shall be retained by the laboratory for a minimum of two years.*
- (4) *Unless otherwise authorized in writing by the third party, laboratories shall retain and place in properly secured long-term frozen storage the remainder of all positive specimens with a positive result at minus ten degrees Centigrade or lower for a minimum of one year all. Within this one year period a third party may request the laboratory to retain the specimen for an additional period of time, but if no such request is received the laboratory may discard the specimen after the end of one year; however the laboratory shall be required to store any specimens under legal challenge for an indefinite period.*
- (5) A retest is not subject to a specific cutoff requirement but must provide data sufficient to confirm the presence of the drug or metabolite.
- (6) Specimens which are negative for the requested substance abuse tests shall be discarded within one week after the reporting of the negative test result.

c. HIV test results.²⁵

- (1) The records of any person that indicate that a person has a human immunodeficiency virus (HIV) infection, AIDS related complex (ARC), or acquired immune deficiency syndrome (AIDS), are strictly confidential. ***"Records" means all communication which identifies any individual who has HIV infection, ARC, or AIDS.*** This information shall not be released or made public upon subpoena or any other method of discovery. Notwithstanding any other provision to the contrary, release of the records protected under this part shall be permitted under the following circumstances:
- (2) Release is made to the Department of Health in order that it may comply with federal reporting requirements imposed on the State. The department shall ensure that personal identifying information from these records are protected from public disclosure.
- (3) Release is made of the records, or of specific medical or epidemiological information contained therein, with the prior written consent of the person or persons to whom the records pertain.
- (4) Release is made to medical personnel in a medical emergency only to the extent necessary to protect the health, life, or well-being of the named party.
- (5) Release of a child's records is made to the Department of Human Services for the purpose of enforcing chapters 350 and 587.

²⁵ The requirements with respect to HIV records are contained primarily in Hawaii Revised Statutes section 325-101.

- (6) Release is made to the patient's health care insurer to obtain reimbursement for services rendered to the patient; provided that release shall not be made if, after being informed that a claim will be made to an insurer, the patient is afforded the opportunity to make the reimbursement directly and actually makes the reimbursement.
- (7) Release is made by the patient's health care provider to another health care provider for the purpose of continued care or treatment of the patient.
- (8) Release is made pursuant to a court order, after an in camera review of the records, upon a showing of good cause by the party seeking the release of the records.
- (9) Recording or maintaining information protected in a separate portion of an individual's file which is clearly designated as confidential shall not be construed as a breach per se of that individual's confidentiality.
- (10) No person shall be compelled to consent to the release of information protected under this part or to disclose whether the person has been tested for the presence of HIV infection in order to obtain or maintain housing, employment, or education.

Exhibit 9

OREGON LAW/AH RECORD RETENTION REQUIREMENTS

All Oregon AH-affiliated laboratories must maintain for at least two (2) years, and for immunohematology tests for at least 5 years, the following information:

- (1) Records of specimens received and tested, including identification of the specimen, identification of the patient, name of the submitter, dates of receipt and report, type of test performed, test results, and signature, initials or identification of the examiner.
- (2) Records of inspection, validation, calibration, repair, and replacement to ensure proper maintenance and operation of equipment and proper reactivity of test materials.
- (3) Manuals, card files, or flow charts for each procedure performed in the laboratory, including the following information:
 - (a) Name of procedure.
 - (b) Source of reference for the test method.
 - (c) Date director or supervisor last reviewed or modified the procedure.
 - (d) Current specific instructions for test performance.
 - (e) Standards and controls required.
 - (f) Instructions for collecting and handling specimens to ensure test reliability.
 - (g) Records of quality control procedures in use in the various technical areas of the laboratory, including results on standards and reference materials and action limits when appropriate.
- (4) Additional requirements for cytology, histology, and tissue blocks: The laboratory must retain all cytology slides and cell blocks for at least five (5) years and all cytology reports for at least ten (10) years, histology slides and reports for at least ten (10) years, and tissue blocks and reports for at least (2) years, and records indicating the daily accession of numbered specimens and an appropriate cross-filing system according to patient's name.

Exhibit 10

WASHINGTON LAW/AH RECORD RETENTION REQUIREMENTS

Washington AH-affiliated laboratories must maintain for at least two (2) years, and for transfusion services for at least five (5) years, the following information:

(1) Records of specimens received and tested, including identification of the patient, name of the submitter, dates of receipt and report, type of test performed, sex and age of patient, if appropriate, and test results.

(2) Records of inspection, validation, calibration, repair, and replacement to ensure proper maintenance and operation of equipment and proper reactivity of test materials.

(3) Quality assurance records, such as manuals, card files, or flow charts for each procedure performed in the laboratory, including the following information:

(a) Name of procedure.

(b) Source of reference for the test method.

(c) Date director or supervisor last reviewed or modified the procedure.

(d) Current specific instructions for test performance.

(e) Standards and controls required.

(f) Instructions for collecting and handling specimens to ensure test reliability.

(g) Records of quality control procedures in use in the various technical areas of the laboratory, including results on standards and reference materials and action limits when appropriate.

(4) Additional requirements for cytology and histology: The laboratory must retain all cytology and histology reports for at least ten (10) years and records indicating the daily accession of numbered specimens and an appropriate cross-filing system according to patient's name.

Exhibit 11

NOTICE

ADVENTIST HEALTH LABORATORY COMPLIANCE PROGRAM
A Personal Commitment to Integrity

It is the policy of Adventist Health (“AH”) to fully comply with all laws, regulations and ethical requirements that apply to health care providers. To help ensure that AH and all AH employees continue to comply with these standards, AH has adopted a Laboratory Compliance Program which formalizes our compliance efforts into a comprehensive program which better defines the responsibilities of all AH employees regarding compliance issues.

AH’s Laboratory Compliance Program is a component of the AH Corporate Compliance Program. The Program reflects AH’s strong commitment to comply with all laws and regulations affecting its laboratory operations.

Each AH-affiliated laboratory will receive a copy of the Laboratory Compliance Program. In addition, a training and education program will help ensure that laboratory employees understand the standards of conduct that they are expected to follow.

The Laboratory Compliance Program is designed to *prevent* violations of applicable laws, regulations, policies and ethical requirements by helping employees choose the proper course of action when faced with difficult compliance issues. Specifically, the Program emphasizes training and encourages employees to seek advice whenever they are at all uncertain as to the proper course of action to take. AH’s Corporate Compliance Officer, the Compliance Officer for Clinical Laboratories, and the facility compliance officer are always available to help answer any questions an employee may have concerning compliance issues.

The Laboratory Compliance Program is also designed to *detect and correct* violations of applicable laws, regulations, policies and ethical requirements. Therefore, it is the duty and responsibility of each employee to report promptly to an appropriate person any violation or potential violation of these standards.

The preferred method of reporting or communicating potential compliance issues, or anything that may otherwise compromise the integrity of AH, is for an employee to first try to speak to his or her supervisor directly. This is consistent with AH’s “open-door” policy. However, in certain situations, an employee may feel uncomfortable discussing a particular situation with his/her supervisor. Therefore, each employee is free to discuss or report any such issues with the facility compliance officer. If the situation is not satisfactorily resolved reports may be made to the Corporate Compliance Officer,

In addition, AH established a toll free telephone number, 1-888-366-3833, through which employees may submit confidential, and if desired, anonymous, reports. This reporting procedure permits any employee to report suspected misconduct or non-compliance by bypassing

normal channels of communication and chains of command. Suspected misconduct and non-compliance issues may also be reported through written reports. Compliance reporting forms are available through the AH-affiliated laboratories' human resource department and/or local compliance officer. To make a written report you may write to **[local compliance officer + address]** or AH's Compliance Coordinator at the address below.

Employees are encouraged to identify themselves when making such reports so that the information can be investigated promptly and thoroughly. However, any report may be made on an anonymous basis. In addition, *no employee will suffer any penalty or retribution for reporting suspected misconduct or non-compliance.*

All such reports will be relayed to **[facility local compliance officer]** for investigation. Any AH employee who is found to have engaged in conduct on behalf of the company in violation of the Laboratory Compliance Program may be subject to prompt and appropriate discipline, up to and including dismissal.

Feel free to contact, verbally or in writing, either of the following with any questions or concerns you may have about the application of any law, regulation or company policy to your laboratory, or any suspected violation of law, company policy or the Laboratory Compliance Program.

[Local Compliance Officer]

[Facility Name]

[Facility Address]

[City], [State] [Zip]

[Telephone number]

[Facsimile number]

Corporate Compliance Officer

Adventist Health

2100 Douglas Boulevard

P.O. Box 619002

Roseville, CA 95661-9002

Tel: (916) 781-4730

Fax: (916) 774-3326

Attachment 12

ADVENTIST HEALTH

LABORATORY COMPLIANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT AND REVIEW

I have received and read a copy of the Laboratory Compliance Program and agree to abide by the policies, rules and regulations contained therein.

I understand that this Laboratory Compliance Program is only a part of Adventist Health policies and that any violation may result in corrective and/or disciplinary action up to and including termination. Adventist Health reserves the right to modify these policies at its sole discretion.

Signature

Date

Adventist Health
Corporate Compliance Program
Part 5: Health Information Management (HIM)
Checklist

Actions relating to the Compliance Program Specifically:

- Review the compliance program with HIM personnel annually.
- Distribute the notice entitled, “A Personal Commitment to Integrity” to each employee.
- Obtain signed “Acknowledgement of Receipt and Review” from each employee.
- Post the “Reporting Compliance Concerns” in a location each employee can view periodically.
- Have the “Compliance Report” form available where employees can pick it up anonymously. These should be available so that employees can use them to report compliance concerns.

Actions required by the Compliance Program Concerning Operations:

Training & Education:

- All staff will be trained concerning federal and state regulations, Corporate policies and procedures, and specific departmental requirements.
- Coding personnel will obtain a minimum 10 hours of continuing education annually.

Documentation:

- The department will follow state and federal guidelines regarding patient medical chart documentation.

Release of Information:

- The department will adhere to state and federal requirements, including HIPAA, with regards to releasing patient information.

Coding:

- Coding staff will follow the policies defined in the HIM compliance program.

Contract Coder/Tumor Registry Requirements:

- Consulting firms and/or contract coding firms will follow specified criteria.

Audits:

- The department will provide periodic coding, documentation, and claims audits.

OIG Fraud Alerts

- Each AH Agency must comply with the applicable OIG Fraud Alerts that are periodically published on the OIG web site.

Other Policies:

- Employees will follow policies and procedures as described in the AH Employee Handbook and other sources.

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ADVENTIST HEALTH
Corporate Compliance Program
PART 5: HEALTH INFORMATION MANAGEMENT
INTRODUCTION

May 2006

Adventist Health (“AH”) has established the following policies and procedures for Health Information Management (HIM) departments in an effort to ensure compliance with applicable state and federal laws. In addition to the following policies, all AH HIM staff are expected to comply with the standards of conduct as set forth in Part 1 of the AH Corporate Compliance Program.

This Part 5 of the Compliance Program establishes AH’s policies and procedures regarding compliance with laws specific to HIM departments. These policies and procedures are intended to assure that AH HIM departments and their employees comply with applicable laws, regulations, manual provisions, other government pronouncements and corporate policies and procedures that relate to HIM departments.

While these policies and procedures highlight federal and state laws specific to HIM, they do not include every legal requirement that applies to HIM departments. Thus, each AH organization must ensure that its HIM department is in compliance with all laws, regulations, other applicable federal and state government pronouncements and corporate policies and procedures. Each HIM department is responsible for the creation, review and maintenance of its own facility specific policies and procedures.

**POLICIES AND PROCEDURES FOR HEALTH INFORMATION
MANAGEMENT**

1. Training and Education

A. All Staff

All staff will participate in training and education that will include federal and state regulations and guidelines, Corporate and local policies and procedures, and specific department requirements. The HIM director/supervisor will complete an orientation checklist for each employee. A sample follows in Attachment 4. Documentation of the completed orientation checklist must be filed in the employee file. Departmental training and educational materials shall be maintained for a period of 6 years.

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B. Coding Personnel

AH believes that our employees should be kept abreast of current regulatory issues related to the practice of clinical coding. In addition, AH believes that all coding staff within AH and contracted coding staff must continue to increase their knowledge regarding coding and DRG/APC assignment updates and changes. Credentialed and non-credentialed hospital and contracted coding staff must obtain and document the minimum amount of continuing education required for credential maintenance. This can be achieved through AH sponsored educational seminars or by other outside entities. Evidence of compliance with this policy shall be met by maintaining copies of continuing education certificates within the HIM/Medical Record Department. It shall be the responsibility of the HIM/Medical Records Department Director to maintain these copies in an accessible file or area.

Non-credentialed hospital coding staff are encouraged to actively pursue recognized coding credentials.

All new employees involved in the coding process or current employees transitioning to a coder position will review coding policies and procedures prior to performing coding functions. Their training will include, but is not limited to the following areas:

- Coding Abstract
- Patient Index
- Patient Account Inquiry
- Standards and reports used by the facility to monitor quality and quantity of coding.

2. Documentation

Each AH HIM department will promote state and federal guidelines with regard to patient medical chart documentation requirements. Addendum to any patient record made by clinical staff must show the date and signature that the addendum was documented.

3. Release of Information

Each AH HIM department will adhere to state and federal laws, including HIPAA regulations affecting privacy and security of patient information, the AH facility confidentiality statement and AH facility-specific policies regarding the release of patient information whether released in written or electronic form.

- Patients are entitled to receive copies or summaries of their records in accordance with state and federal regulations and AH facility specific policies.
- Confidential patient information may only be disclosed in response to a HIPAA-compliant legal or authorized request.

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- HIM directors, in conjunction with facility Privacy Officials, are responsible for providing release of information training for HIM Department staff.
- Contracted copy and release of information service vendors must sign a HIPAA Business Associate Agreement and facility confidentiality statement. Such vendors must also complete facility-specific HIPAA training prior to commencing services onsite.

4. Coding

The following policies are established to promote consistency and continuity across the AH Healthcare System's many settings, while achieving quality coded healthcare data. Each Health Information Management/Medical Record Department shall adhere to the following Coding/HIM compliance policies at all times:

A. All coding staff within the AH system will adhere to the AHIMA, Standards of Ethical Coding (See Attachment 3). A copy of this document shall be retained within the department manual of each Health Information Management Department or coding entity. This document shall be reviewed with all “new hire” coding employees and annually (during performance evaluation) thereafter.

B. Every employee and/or contract employee who performs the function of clinical coding shall read the AH System-wide Coding/HIM Compliance Policies. These policies shall be signed by the individual to acknowledge an adherence to the policies and an understanding of their content. Copies of these acknowledgements shall be kept in the individual personnel file.

C. Each individual and/or entity that performs the clinical coding function within the AH system must at all times utilize and adhere to AHA’s publication *Coding Clinic* and *Official Guidelines for Coding and Reporting*, as these are the CMS approved guidelines for ICD coding. The *CPT Assistant* guidelines published by the AMA must also be used for CPT coding, as an official source document. These guidelines are programmed into facility coding software tools.

D. At a minimum, the following resources and reference materials shall be maintained within every Health Information Management Department and be accessible to the coding staff:

- Current ICD and CPT code resources
- AMA Current Procedural Classification System (HCPCS) resources
- Current encoder subscriptions to AHA’s *Coding Clinic* and AMA’s *CPT Assistant*
- Maintain a copy of the *Coding Clinic Official Guidelines for Coding and Reporting*
- Anatomy/Physiology resources
- Medical Dictionary
- *Physicians Desk Reference*, drug reference book or hospital formulary
- Fiscal Intermediary and Carrier Transmittals/Program Memorandums
- Medicare Bulletins

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E. A qualified coder will assign All ICD and CPT codes. This could be a CCS, CPC, RHIA, RHIT, CCA an individual with multiple years of coding experience and knowledge, or an individual under appropriate HIM supervision who is pursuing coding credentials. Staff provided by outside contracted coding services must be credentialed.

F. Emergency visit level CPT codes will be assigned via corporate-adopted algorithm embedded in approved software and supported by clinical documentation, or by a qualified coder. A qualified coder will assign all Emergency Department ICD and CPT codes. This could be a CCS, CPC, RHIA, RHIT, CCA, an individual with multiple years of coding experience and knowledge, or an individual under appropriate HIM supervision who is pursuing coding credentials. Staff provided by outside contracted coding services must be credentialed.

G. A qualified coder will assign all Hospital Owned and Managed Physician Clinic ICD and CPT codes. This could be a CCS, CPC, RHIA, RHIT, CCA, an individual with multiple years of coding experience and knowledge, or an individual under appropriate HIM supervision who is pursuing coding credentials. Staff provided by outside contracted coding services must be credentialed. Hospital HIM Directors will work with clinic management in an over sight/consultation role to ensure quality coding. In addition, HIM Directors or their designees will participate in chart audits for clinic coding personnel education purposes. (Hospital owned physician clinics operate under Part 7 of the Adventist Health Compliance Program for Hospital Owned Physician Clinics.)

H. All ICD and CPT codes shall be assigned based upon documentation recorded by a physician or mid-level provider such as a nurse practitioner or physician assistant. Midlevel provider documentation must be compliant with State regulations governing the provider and facility, and medical staff organization credentialing, privileging, and rules and regulations. If, at any time, there isn't sufficient documentation for which to base code assignments (i.e., missing operative reports, pathology reports, progress notes, ancillary reports, etc.), the coding staff must contact the responsible clinician and defer coding until the necessary documentation is obtained or is available.

I. Any acute care inpatient record that is coded without a discharge summary must have enough documentation in the progress notes to assure accuracy of the final code assignments.

J. When coding Outpatient Surgery (OPS) records and the coder finds that the operative report/note, pathology report, or other physician operative documentation is not available; the coding process should be halted or deferred until this report is available. It is strongly recommended that the responsible physician be contacted in order to finalize the record completion process.

K. Each patient record should have the complete ICD and CPT codes assigned in the coding abstract.

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- L. Modifiers should be assigned in accordance with CMS and AMA guidelines.
- M. When the coder identifies inadequate, conflicting or illegible documentation in the record, the facility's physician query policy and procedure must be followed and the responsible physician contacted to resolve the issue and add clarifying documentation in the record.
- N. If a coding question develops regarding the correct methodology or code assignment to use the coder should seek clarification from *Coding Clinic* or *CPT Assistant*. If the coding question is not resolved the immediate supervisor should be contacted. If the issue needs further assistance the supervisor and coder shall seek outside consultation.
- O. The coder shall not, at any time, add codes solely based on test results.
- P. The coder shall not, at any time, report diagnoses and/or procedures that the documentation does not support.
- Q. The coder shall not, at any time, misrepresent the patient's clinical picture through incorrect coding, or add diagnoses/procedures unsupported by the documentation in order to maximize reimbursement or meet insurance company coverage requirements.
- R. The coder shall not, at any time, make coding changes to the completely coded medical record post billing without supporting medical record documentation to do so.
- S. The coder and coding staff shall refuse to participate in illegal or unethical business acts and refuse to conceal the illegal or unethical acts of others.
- T. It is the responsibility of the coder to report any unethical practices in accordance with the Adventist Health Code of Conduct as contained in Part 1 of the Adventist Health Compliance Program.
- U. The coder shall at all times respect the confidentiality of patient identifiable health information and follow established healthcare confidentiality policies within the facility.
- V. The coder and/or coding staff should strive for a positive working relationship with physicians and other clinicians through communication, education and open dialogue.

STATUTORY/REGULATORY AUTHORITY SOURCE: OIG Guidance for Hospitals, AHIMA; Health Information Management Compliance: A Model Program for Healthcare Organizations.

5. Contract Coder/Tumor Registry Requirements

AH affiliates may utilize the services of consultation firms and/or contract coding firms/personnel. All contracted firms/personnel will:

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- Read and sign a facility confidentiality statement
 - Sign a HIPAA Business Associate Agreement
 - Read and sign the Compliance Program requirements
 - Provide a copy of the contracted company's compliance program (not applicable to contracted individuals, only contracted companies)
 - Read and sign computer access forms
 - Provide a copy of credentials to the facility
 - Take a coding test provided by facility (if required)
-
- On-site contracted personnel should be oriented to the facility with regards to HIPAA Privacy and Security policies and procedures, fire, MSDS, safety, disaster procedures, identification badges, emergency phone numbers, infection control, etc.)

6. Audits

AH affiliates may engage outside consultation firms to perform coding, and/or reimbursement audits, and to provide legal counsel.

A. Coding/Document Audits

To promote quality coding, a quarterly coding review process will be implemented by each AH affiliate in accordance with the Corporate Coding Audit Policy. Coding issues identified will be addressed and communicated, as needed, to the Patient Financial Services Department for re-billing purposes. Adverse trends will be reported to the HIM director/supervisor and Local Compliance Officer and resolved immediately.

B. Claim Audits

To prompt the submission of accurate claims, AH affiliates will follow the Adventist Health Claim Audits policy, PFS-155. Audits can be performed at any time when an issue is identified.

Inaccuracies that result from claims audits must be submitted for charge correction and re-billing, if appropriate. Adverse trends will be reported to the Department Directors and Local Compliance Officer and resolved immediately.

7. Compliance with Applicable HHS/OIG Fraud Alerts

Each AH HIM department will comply with the requirements of fraud alerts that are issued by the government. Such material should be readily accessible to HIM department personnel. They may also be accessed at the U.S. Government's Department of Health and Human Services Office of Inspector General's web site. Any questions regarding compliance with fraud alert requirements should be directed to the Local Compliance Officer.

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8. Other policies:

- A. Employee responsibilities as described in the AH Facility Employee Handbook
- B. Confidentiality, see your Employee Handbook and HIPAA Privacy and Security policies.
- C. Conflict of Interest, see your Employee Handbook
- D. Record Retention, see the AH Record Retention Policy

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Attachment 1

NOTICE

**ADVENTIST HEALTH, HEALTH INFORMATION MANAGEMENT
COMPLIANCE PROGRAM
A Personal Commitment to Integrity**

It is and has always been the policy of Adventist Health (“AH”) to fully comply with all laws, regulations and ethical requirements that apply to health care providers. To help ensure that AH and all AH employees continue to comply with these standards, AH has adopted a Health Information Management Department Compliance Program which formalizes our compliance efforts into a comprehensive program which better defines the responsibilities of all AH employees regarding health information compliance issues.

AH’s Health Information Management Department Compliance Program reflects AH’s strong commitment to comply with all laws and regulations affecting it’s Health Information Management Department operations.

Each AH-affiliated Health Information Management Department will receive a copy of the Health Information Management Department Compliance Program. In addition, a training and education program will help ensure that HIM department employees understand the standards of conduct that they are expected to follow.

The Health Information Management Department Compliance Program is designed to *prevent* violations of applicable laws, regulations, policies and ethical requirements by helping employees choose the proper course of action when faced with difficult compliance issues. Specifically, the Compliance Program emphasizes training and encourages employees to seek advice whenever they are uncertain as to the proper course of action to take. An employee’s supervisor, local director, local facility compliance officer, and the Corporate Compliance Officer are always available to help answer any questions an employee may have concerning compliance issues.

The Health Information Management Department Compliance Program is also designed to *detect and correct* violations of applicable laws, regulations, policies and ethical requirements. Therefore, it is the duty and responsibility of each employee to report promptly to an appropriate person any violation or potential violation of these standards.

The preferred method of reporting or communicating potential compliance issues or anything that may otherwise compromise the integrity of AH is for an employee to first speak to his or her supervisor directly. This is consistent with AH’s “open-door” policy. However, in certain situations, an employee may feel uncomfortable discussing a particular situation with his or her supervisor. Therefore, each employee is free to discuss or report any suspected misconduct or non-compliance to their local director, local facility compliance officer, or the Corporate Compliance Officer.

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In addition, AH established a toll free telephone number, 1-888-366-3833, through which employees may submit confidential, and if desired, anonymous, reports. This reporting procedure allows employees to report suspected misconduct or non-compliance by bypassing normal channels of communication and chains of command. Suspected misconduct and non-compliance issues may also be reported through written reports. Compliance reporting forms are available through the AH-affiliated home health agency's human resource department and/or local compliance officer. To make a written report you may write to your local compliance officer or AH's Corporate Compliance Officer at the addresses below.

Employees are encouraged to identify themselves when making such reports so that the information can be investigated promptly and thoroughly. However, any report may be made on an anonymous basis. In addition, *no employee will suffer any penalty or retribution for reporting suspected misconduct or non-compliance.*

All such reports will be relayed to local compliance officer for investigation. Any AH employee who is found to have engaged in conduct on behalf of the company in violation of the Health Information Management Department Compliance Program may be subject to prompt and appropriate discipline, up to and including dismissal.

Feel free to contact, verbally or in writing, the following with any questions or concerns you may have about the application of any law, regulation or company policy to your organization, or any suspected violation of law, company policy or Health Information Management Department Compliance Program.

[Local Compliance Officer]

[Facility]

[Address]

[City], [State] [Zip]

Tel: (xxx) xxx-xxxx

Fax: (xxx) xxx-xxxx

Corporate Compliance Officer

Adventist Health

2100 Douglas Boulevard

P. O. Box 619002

Roseville, CA 95661-9002

Tel: (877) 336-3566

Tel: (916) 781-4730

Fax: (916) 774-3382

Corporate Compliance Program, Part 5

Revised May 2006

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Attachment 2

ADVENTIST HEALTH
HEALTH INFORMATION MANAGEMENT
COMPLIANCE PROGRAM
ACKNOWLEDGMENT OF RECEIPT AND REVIEW

I have received and read a copy of the Health Information Management Compliance Program and agree to abide by the policies, rules and regulations contained therein and the Personal Commitment to Integrity notice (Attachment 1).

I understand that this Health Information Management Compliance Program is only a part of Adventist Health policies and that any violation may result in corrective and/or disciplinary action up to and including termination. Adventist Health reserves the right to modify these polices at its sole discretion.

Signature

Date

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Attachment 3
AHIMA Standards of Ethical Coding (Revised 12/99)

In this era of payment based on diagnostic and procedural coding, the professional ethics of health information coding professionals continue to be challenged. A conscientious goal for coding and maintaining a quality database is accurate clinical and statistical data. The following standards of ethical coding, developed by AHIMA's Coding Policy and Strategy Committee and approved by AHIMA's Board of Directors, are offered to guide coding professionals in this process.

1. Coding professionals are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality healthcare data.
2. Coding professionals in all healthcare settings should adhere to the ICD-9-CM (International Classification of Diseases, 9th revision, Clinical Modification) coding conventions, official coding guidelines approved by the Cooperating Parties,¹ the CPT (Current Procedural Terminology) rules established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets. Selection and sequencing of diagnoses and procedures must meet the definitions of required data sets for applicable healthcare settings.
3. Coding professionals should use their skills, their knowledge of currently mandated coding and classification systems, and official resources to select the appropriate diagnostic and procedural codes.
4. Coding professionals should only assign and report codes that are clearly and consistently supported by physician documentation in the health record.
5. Coding professionals should consult physicians for clarification and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record.
6. Coding professionals should not change codes or the narratives of codes on the billing abstract so that meanings are misrepresented. Diagnoses or procedures should not be inappropriately included or excluded because payment or insurance policy coverage requirements will be affected. When individual payer policies conflict with official coding rules and guidelines, these policies should be obtained in writing whenever possible. Reasonable efforts should be made to educate the payer on proper coding practices in order to influence a change in the payer's policy.
7. Coding professionals, as members of the healthcare team, should assist and educate physicians and other clinicians by advocating proper documentation practices, further specificity, and resequencing or inclusion of diagnoses or procedures when needed to more accurately reflect the acuity, severity, and the occurrence of events.
8. Coding professionals should participate in the development of institutional coding policies and should ensure that coding policies complement, not conflict with, official coding rules and guidelines.

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9. Coding professionals should maintain and continually enhance their coding skills, as they have a professional responsibility to stay abreast of changes in codes, coding guidelines, and regulations.

10. Coding professionals should strive for optimal payment to which the facility is legally entitled, remembering that it is unethical and illegal to maximize payment by means that contradict regulatory guidelines.

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Attachment 4

Orientation Checklist
(Sample, not intended to be all inclusive)

Scope: All Health Information Management personnel must have an orientation checklist completed.

Directions: The supervisor and/or the employee will check and initial under the appropriate column for each designated task. The supervisor must complete the date the task was achieved. The supervisor will indicate NA (not applicable) in the date column for any resource not reviewed due to the fact it is not applicable to position responsibility.

Employee's Name: _____

Hire Date: _____

	Supervisor			Employee	Date
<i>1. General Issues:</i>					
<i>Review of job description and performance evaluation process</i>	_____	_____	_____	_____	_____
<i>Dept. Mission, Vision, & Values</i>	_____	_____	_____	_____	_____
<i>Dept. organization chart</i>	_____	_____	_____	_____	_____
<i>Employee Handbook</i>	_____	_____	_____	_____	_____
<i>Dept. policies & procedures</i>	_____	_____	_____	_____	_____
<i>Staff meetings and events</i>	_____	_____	_____	_____	_____
<i>Medical Staff by-laws</i>	_____	_____	_____	_____	_____
<i>HIM library & reference materials</i>	_____	_____	_____	_____	_____
<i>Safety & fire practice guidelines</i>	_____	_____	_____	_____	_____
<i>Disaster plan</i>	_____	_____	_____	_____	_____
<i>Hazardous material protocol</i>	_____	_____	_____	_____	_____
<i>MSDS sheets</i>	_____	_____	_____	_____	_____
<i>Infection control procedures</i>	_____	_____	_____	_____	_____
<i>Confidentiality</i>	_____	_____	_____	_____	_____
<i>2. Office equipment usage:</i>					
<i>Telephone</i>	_____	_____	_____	_____	_____
<i>Fax</i>	_____	_____	_____	_____	_____
<i>Copy machine</i>	_____	_____	_____	_____	_____
<i>Computer access, passwords, etc.</i>	_____	_____	_____	_____	_____
<i>Laser printers</i>	_____	_____	_____	_____	_____
<i>Time card machine</i>	_____	_____	_____	_____	_____
<i>Dictation system</i>	_____	_____	_____	_____	_____
<i>Transcription system</i>	_____	_____	_____	_____	_____
<i>3. Software programs/systems</i>					
<i>Master Patient Index</i>	_____	_____	_____	_____	_____
<i>Chart deficiency</i>	_____	_____	_____	_____	_____
<i>Unit consolidation/duplicate MR#</i>	_____	_____	_____	_____	_____
<i>Release of information</i>	_____	_____	_____	_____	_____
<i>4. Tour of facility</i>	_____	_____	_____	_____	_____
<i>5. Tour of department</i>	_____	_____	_____	_____	_____
<i>6. Quality improvement activities</i>	_____	_____	_____	_____	_____

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7. Compliance reporting guidelines & phone numbers _____

8. Filing systems:

On-site/off-sit _____

Terminal digit filing/chart retrieval _____

Chart assembly _____

Loose filing _____

9. Monthly statistics (SIMS) _____

10. Chart deficiency analysis _____

11. Unit consolidation/duplicate MR# _____

12. Record retention, back -up system _____

13. Occurrence report _____

14. Birth certificate processing _____

Prior to beginning the coding process:

1. Review of corporate coding policies and procedures _____

2. Review of facility coding policies and procedures _____

3. Review of AHIMA Ethical Standards of Coding _____

4. Review of AH Corporate Compliance Program,
Part 5 _____

5. Coding abstract

Inpatient _____

Outpatient _____

6. Unbilled reports _____

7. Patient account inquiry _____

8. Overview of coding quality and quantity standards and reports _____

9. Review of reference material _____

10. Data-flow orientation _____

Employee's Signature _____

Supervisor's Signature _____

Supervisor's Title: _____

Date Completed _____

This form must be maintained in the employee's file.

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Attachment 5

*[This is designed to be printed on a half sheet
of 8 ½ x 11 paper and posted in the HIM Department
for a reminder to employees of their reporting options.]*

**Adventist Health Compliance Program
Reporting Compliance Concerns**

Adventist Health supports and encourages each employee to maintain individual responsibility for monitoring and reporting any activity by any employee or contractor that appears to violate any applicable laws, rules, regulations or this Compliance Program. Adventist Health's self-monitoring compliance program provides a confidential reporting system with the following options available for handling your Compliance Program concerns:

- **Supervisor**
- **Local Compliance Officer-** Currently the Local Compliance Officer is [*INSERT NAME OF LOCAL COMPLIANCE OFFICER*], who can be reach at (___ - ___ - ___).
- **Compliance Report Form-** The forms are available from various locations in your facility, your human resource department, and your Local Compliance Officer.
- **Hotline** - A special toll- free telephone line is dedicated to reporting Compliance Program concerns. Please be prepared to provide details of the situation. The toll- free number is 1-888-366-3833 (Operators are available 8 a.m. to 5 p.m. Pacific Time, Monday-Thursday; 8 a.m. to 3:30 p.m. Pacific Time, Friday. Messages may be left during weekends and after-hours).
- **Corporate Compliance Officer-** Adventist Health, P. O. Box 619002, Roseville, CA 95661-9002.

**PRIVILEGED AND CONFIDENTIAL
ATTORNEY-CLIENT COMMUNICATION
ATTORNEY WORK PRODUCT**

July 16, 1999

**ADVENTIST HEALTH
Corporate Compliance Program**

PART 6: HOSPITAL PATIENT BILLING

I.

INTRODUCTION

Adventist Health (“AH”) has established the following policies and procedures for its affiliated hospital’s patient financial services departments (collectively, “Financial Services Departments”) in an effort to ensure compliance with applicable state and federal laws.

This Part 6 of the Compliance Program establishes AH’s policies and procedures regarding compliance with laws specific to Financial Services Departments and their functions. These policies and procedures are intended to assure that AH Financial Services Departments and their employees comply with applicable laws, regulations, manual provisions and other government pronouncements that relate to their functions and services.

While these policies and procedures highlight federal and state laws specific to Financial Services Department functions and services, they do not include every applicable legal requirement. Thus, each AH organization must ensure that its Financial Services Department is in compliance with all laws, regulations and other applicable federal and state government pronouncements.

II.

INTENT

The following policies and procedures are a component of the AH Corporate Compliance Program. These policies and procedures reflect AH’s strong commitment to comply with all laws and regulations affecting its patient financial services operations.

Each AH Financial Services Department will receive a copy of these policies and procedures. In addition, a training and education program will help ensure that employees understand the standards of conduct that they are expected to follow.

These policies and procedures are designed to *prevent* violations of applicable laws, regulations, policies and ethical requirements by helping employees choose the proper course of action when faced with difficult compliance issues. Specifically, these policies and procedures

Revised November 30, 2000

encourage employees to seek advice whenever they are uncertain as to the proper course of action. The employee's supervisor, local director, local compliance officer, and AH's Corporate Compliance Officer are always available to help answer any questions an employee may have concerning compliance issues.

These policies and procedures are also designed to *detect and correct* violations of applicable laws, regulations, policies and ethical requirements. Therefore, it is the duty and responsibility of each employee to report promptly any violation or potential violation of these standards to the appropriate person.

III.

POLICIES AND PROCEDURES FOR PATIENT FINANCIAL SERVICES

A. Introduction

The development and submission of health care claims is a complicated process that involves input and cooperation from virtually every department in a health care organization. AH affiliates provide inpatient and outpatient services to individuals referred by personal physicians or emergency department physicians. The inpatient, outpatient, and ancillary departments should make every effort to provide services only to patients for whom a physician order or requisition has been received. AH affiliates recognize that licensed health care professionals must be able to order any services that in their judgment are deemed necessary for the treatment of their patients. However, Medicare and other third parties will only pay for those services that meet appropriate medical necessity standards. Such standards may differ from the licensed health professional's judgment regarding services needed to treat their patients.

From the receipt of the physician's order, every hospital department is responsible for implementing and maintaining policies and procedures that ensure appropriate record retention of the physician's orders; clear and appropriate documentation in patient charts of services provided; timely and accurate recording in the electronic information systems of services performed; and proper maintenance of data bases and systems that generate claims for submission to the third-party payors.

Each Financial Services Department is responsible for generating and submitting claims for services to the various third-party payors. This is accomplished through accounts receivable information systems, which contain databases that reflect the information entered by the Patient Care Departments, Information Systems, and Health Information Management. Each Financial Services Department is responsible for interfacing with the third-party payors, establishing policies and procedures to ensure that third-party payor reimbursement information is properly reflected in the information systems, cooperating with other departments to ensure that the charge description masters accurately reflect the services provided by the provider, and generating claims that meet the third-party payor claims submission criteria. Each Financial Services Department is also in a unique position to help communicate changes regarding payor standards to the Health Care Services Departments.

1. Standards of Conduct

AH is committed to properly coding and billing for the services its facilities render in accordance with all applicable laws. AH does not tolerate fraud and abuse by its agents or employees. Accordingly, it is AH's express intention that each and every Financial Services Department employee prevent, discourage, and/or halt any such fraud, waste, and abuse or unethical activity discovered. Any activity that violates this policy must be reported immediately. Such reports may be made verbally to the supervisor, local director, local facility compliance officer, the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities' compliance officer. It should be clearly indicated on the report if anonymity is desired.

Moreover, AH encourages and expects full adherence to all guidelines and regulations governing federally and state funded health care programs, as distributed from time to time by the AH affiliates fiscal intermediary/carrier or other government agency (e.g., new billing procedures, fraud alerts, etc.).

B. Billing Policies and Procedures

Each Financial Services Department shall develop and implement written policies and procedures in specific areas of compliance risk, which shall include, but not be limited to:

1. Medical Necessity

Policies and procedures to ensure that claims are only submitted for services that the provider has reason to believe are medically necessary, that were ordered by a physician or other appropriately licensed individual and were properly documented. AH affiliates recognize that licensed health care professionals must be able to order any service that in their judgment is deemed necessary for the treatment of their patients. However, Medicare and other third parties will only pay for those services that meet appropriate medical necessity standards. Such standards may differ from the licensed health professional's judgment regarding services needed to treat their patients. The Financial Services Departments are in a unique position to help communicate changes in medical necessity standards as published by the fiscal intermediaries to the health care professionals and the various departments affected by these changes.

2. Billing for Items or Services Not Actually Rendered

Policies and procedures to ensure that claims are only submitted for services that are both ordered and performed. These policies should be so designed to prevent billings for items or services that are not actually rendered or properly ordered.

3. Duplicate Billings

Policies and procedures to ensure that claims are not submitted in a manner that result in inappropriate reimbursement. If any Financial Services Department becomes aware of duplicate payments received for claims, it will refund the inappropriate payments and initiate corrective actions, as necessary, to avoid duplicate payments.

4. Unbundling

Policies and procedures to ensure that claims for services that are required to be bundled together are submitted as a single unit or procedure (i.e., bundled).

5. Charge Description Master Maintenance/ Selection of CPT or HCPCS Codes

The Charge Description Master is a data base in AH's Accounts Receivable Information System that plays a critical role in translating services provided by the organization into individual charges and procedures listed on claim forms and billing statements. It contains service descriptions, Current Procedural Terminology codes (CPT), HCFA's Common Procedural Coding System codes (HCPCS), Revenue Center codes, Accounting codes, and other codes used to identify the services provided. It also plays a key role in generating revenue for the organization.

Each Financial Services Department, in cooperation with other hospital departments, will establish policies and procedures to ensure that the Charge Description Master is properly maintained and updated on a routine basis. Such policies and procedures will also define which personnel have access to and can make revisions to the Charge Description Master. At a minimum, the Charge Description Master should be reviewed and updated on an annual basis. This review may be conducted by trained internal staff or through contracting with an outside consultant with knowledge and experience conducting such reviews. The Financial Services Departments may use computer software tools that facilitate this review process.

The assignment of CPT/HCPCS codes is a cooperative effort between Patient Financial Services, Health Information Management, and the AH affiliate departments that provide health care services to patients. Through this cooperative effort, the AH affiliate will ensure that the CPT or HCPCS codes that are used to bill Medicare, Medicaid, and other third-party payors accurately describe the services that were ordered and performed. Additionally, each Financial Services Department will require review of all applicable CPT/HCPCS codes by individuals (or a committee) from a hospital department with expertise in CPT/HCPCS coding before such codes are approved for claims submissions.

Every Financial Services Department employee is required to (i) immediately report any actual or suspected coding abuse,¹ including any potential "up-coding," and (ii) in the event of any confusion regarding proper code selection, ask the appropriate supervisory personnel for guidance. Additionally, each Financial Services Department should direct billing questions to its Medicare intermediary or carrier. Any instructions received from the Medicare Intermediary or carrier should be documented in a memorandum. These memoranda should be retained by the Financial Services Department. In some cases, it may be appropriate to follow up any

¹ Such reports may be made verbally to the supervisor, local director, local facility compliance officer for that agency, the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities' compliance officer. Please clearly indicate on the report if anonymity is desired.

conversations with a confirming letter. In such cases, the Financial Services Department should keep a copy of the confirming letter for its records.

6. IS Accounts Receivable Billing Editor Maintenance

Each Financial Services Department, in cooperation with the Information Systems Department, should ensure that the accounts receivable billing editor is properly maintained and updated on a routine basis.

7. 3-Day Window

Each Financial Services Department should implement and maintain software edits in the accounts receivable editor that will identify all outpatient services that must be combined with an inpatient stay claim. These edits look at the patient account files to identify outpatient claims that should be combined with an inpatient stay. When the edit receives an outpatient claim it looks at the patient account files to identify inpatient stays with which the outpatient claim should be combined. If such accounts are identified the edit will place the active claim on hold for manual intervention and review by a trained billing staff member.

8. Billing for Discharges in lieu of Transfers

Proper coding of each patient's discharge disposition is important to ensure that the hospital is reimbursed properly for services provided to inpatients. The reimbursement for a patient discharged home is different than for a patient transferred to another health care provider, such as another acute care hospital, skilled nursing facility, or home health agency.

Each Financial Services Department should periodically perform, at least quarterly, routine reviews of claims to determine whether the patient's discharge disposition is appropriate. This review should include pulling a judgmental sample of 10 to 15 claims prior to the release of the claims. Staff should identify the patients and medical record numbers. Staff should then give the list to medical records who will list the discharge disposition per the patient's medical record. This information should then be compared to the discharge code on the claim form or billing statement. If there are any discrepancies, the staff should make any necessary corrections and perform follow up procedures to ensure that the coding of disposition codes is appropriate.

9. Credit Balances

Each Financial Services Department should ensure that timely and appropriate identification of credit balances takes place and that prompt refunds are made for overpayments. Review of reports of credit balances and adjustments should be done on a routine basis, at least quarterly.

10. Medicare Bad Debts

The Medicare program reimburses health care providers for allowable Medicare bad debts resulting from uncollected Medicare beneficiary's deductibles and coinsurance amounts for covered services. The debt must meet the following criteria to be an allowable bad debt:

- a. The debt must be related to covered services and derived from deductible and coinsurance amounts;
- b. The provider must be able to establish that reasonable collection efforts were made;
- c. The debt was actually uncollectible when claimed as worthless;
- d. Sound business judgment established that there is no likelihood of recovery at any time in the future.

If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill was mailed, the debt may be deemed uncollectible. If the provider can document that the beneficiary is medically indigent, the debt may be deemed uncollectible without applying the 120 day requirement.

Each Financial Services Department should establish policies and procedures to ensure that reasonable collection efforts are made to collect Medicare deductible and coinsurance amounts. These efforts must be similar to efforts the provider would put forth to collect comparable non-Medicare patient debts. Each Financial Services Department should issue a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's obligations. Documentation and notes to the patient account must indicate that a genuine collection effort was made through subsequent billings, collection letters, telephone calls and/or personal contacts. Collection efforts may include the use of collection agencies, however, collection agency efforts should be similar to efforts put forth for non-Medicare patients.

Each Financial Services Department, along with Financial Accounting personnel, should develop a review process to determine, at least annually, whether: a) it is properly reporting bad debts to Medicare; and b) all Medicare bad debt expenses claimed are in accordance with applicable federal and state statutes, regulations, guidelines and policies. Such review should ensure that the Financial Services Department and the Financial Accounting Department have appropriate mechanisms in place regarding Medicare bad debts to ensure that routinely waived Medicare copayments and deductibles, if any, are not reimbursed through the cost report. If questions arise, the Department should consult the appropriate billing manual and may choose to consult with the appropriate fiscal intermediary as to bad debt reporting.

11. Selection of ICD-9CM Codes

American Hospital Association's International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is the disease classification system used in the healthcare industry for coding patient diseases (also referred to as diagnoses). The assignment of ICD-9CM codes is a complex process that requires attending physicians and/or qualified coders who review the patient's documented medical information to select the code that most accurately describes the patient's disease. Each AH affiliate Health Information Management Department is primarily responsible for ensuring that only qualified personnel with special training and/or experience in coding standards, will be responsible for reviewing and/or assigning these codes.

Each Financial Services Department is responsible for ensuring that policies and procedures are in effect to ensure that claims are not submitted to Medicare, Medicaid, or other third-party payors without ICD-9CM codes. Through a cooperative effort by all departments involved, each AH affiliate should only submit claims that contain diagnostic information that most accurately describes the diagnosis provided by the ordering physician.

The Financial Services Departments are prohibited from: (1) using diagnostic information provided by the physician from earlier dates of service (other than standing orders, as discussed below); (2) using “cheat sheets” that provide diagnostic information that has triggered reimbursement in the past; (3) using computer programs that automatically insert diagnosis codes without receipt of diagnostic information from the physician and review by qualified personnel; and (4) making up diagnostic information for claim’s submission purposes. Any person aware of any such activity at any AH-affiliated organization should immediately notify their immediate supervisor.² Any claims that are missing diagnostic information should be referred back to Health Information Management for review and follow up.

12. Claim Denials

Each Financial Services Department should ensure that appropriate policies and procedures are in place to address the issue of claim denials, underpayments, improperly paid claims, and claims not paid according to contract. Clarification from providers should be obtained when documentation is confusing or lacking adequate justification.

13. Compensation of Billing Staff, Coding Staff, and Billing/Coding Consultants

Each Financial Services Department should review billing and coding staff compensation arrangements to ensure that any incentive or productivity arrangements do not provide financial incentives to improperly upcode or otherwise inflate claims. Each Financial Services Department should give careful consideration to compensation arrangements paid to billing or coding consultants to ensure that the arrangements do not provide improper incentives.

14. Proper Use of Modifiers

Each Financial Services Department should establish policies and procedures regarding the use of modifiers to ensure compliance with Medicare and other third party payor guidelines.

15. Waiver of Copayments/Discounts

Each Financial Services Department should establish policies and procedures regarding the waiver of copayments/discounts. In general, such waivers/discounts are prohibited unless made in compliance with AH’s Discount Policy.

² Such reports may also be made verbally to the supervisor, local director, local compliance officer for that agency, the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities’ compliance officer. Please clearly indicate on the report if anonymity is desired.

16. Records Retention

Each Financial Services Department should establish policies and procedures regarding the retention of documents as required by either federal or state law and the program requirements of federal, state and private health plans and in accordance with AH's documentation retention guidelines. These policies should include all documents related to the billing and coding process.

C. Documentation

Health care providers are required by federal and state agencies, JCAHO, and third-party payors to keep adequate documentation concerning services performed in the treatment of patients. Each department throughout the continuum of care, from physician offices, patient registration, patient care departments, coding and billing, are expected to implement policies and procedures that provide for careful recording, collecting, and retention of documents supporting the services provided to patients. This documentation must be sufficient to show, as evidence, that services were actually performed, and should support the coding reported for reimbursement purposes, prior to submitting a claim for such services.

D. Training and Education

AH requires that all Financial Services Department employees be knowledgeable regarding the laws and regulations pertaining to billing and coding. The proper education and training of such employees is a significant element of the AH Corporate Compliance Program. Each Financial Services Department should identify all affected employees with significant compliance responsibilities within his or her control and provide appropriate training and continuing education to these affected employees. The training and continuing education plan should include:

1. Job competency testing and training to ensure an appropriate level of knowledge for specific job requirements;
2. Regulatory compliance training on an annual basis, including appropriate training in federal and state statutes, regulations and guidelines, and general education on AH's Corporate Compliance Program; and
3. On-going training through the use of staff meetings, training videos, off-site training seminars, fiscal intermediary/carrier bulletins and publications, national and state patient financial services association materials, government publications and other materials that enhance employee knowledge regarding their responsibilities and compliance education. Training topics should include:
 - Specific government and private payor reimbursement guidelines;
 - "General" prohibitions on paying and receiving remuneration to induce referrals;
 - Who is responsible for the proper selection and sequencing of diagnoses codes;

- Improper alterations to documentation;
- Submitting a claim for physician services when rendered by a non-physician (i.e., the “incident to” rule and the physician physical presence requirement);
- Proper documentation of services rendered, including the correct application of official coding rules and guidelines;
- Signing a form for a physician without the physician’s authorization; and
- Duty to report misconduct.

E. Claims Audits.

Each Financial Services Department should ensure that a process has been established and maintained for pre- and/or post-submission review of claims to ensure claims submitted for reimbursement accurately represent services provided, are supported by sufficient documentation and are in conformity with any applicable coverage criteria for reimbursement. Each AH-affiliated organization may arrange for a periodic reimbursement audit in consultation with legal counsel to ensure accuracy in coding and billing for the facility’s services.

F. Compliance with Applicable HHS OIG Fraud Alerts

Each Financial Services Department should comply with the requirements of fraud alerts that are issued by the government from time to time. AH compliance officers will, in consultation with legal counsel, disseminate applicable fraud alert requirements in the most effective and efficient manner to each Financial Services Department. In addition, the actual fraud alert shall be forwarded to each Financial Services Department by the local compliance officer. Such material should be readily accessible to Financial Services Department employees. Any questions regarding compliance with fraud alert requirements should be directed to the local compliance officer.

G. Employees

1. Each person involved in the billing for reimbursement purposes will (1) receive and review those Financial Services Department policies and procedures applicable to their job performance; (2) discuss with their supervisor or the supervisor’s designee the standards of conduct required under such policies; (3) sign an acknowledgment (substantially in the form as Attachment 1) that they have complied with (1) and (2) herein and will abide by such policies; and (4) receive and review Attachment 2, “A Personal Commitment to Integrity” notice. New employees involved in the billing and compliance related positions should also fulfill these requirements.

2. Each Financial Services Department should post in common work areas a notice that details AH’s commitment to comply with applicable federal and state law in the conduct of its operations. The notice shall be substantially in the form as Attachment 3.

Attachment 1

ADVENTIST HEALTH

HOSPITAL PATIENT BILLING

COMPLIANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT AND REVIEW

I have received and read a copy of the Hospital Patient Billing Compliance Program and agree to abide by the policies, rules and regulations contained therein.

I understand that this Hospital Patient Billing Compliance Program is only a part of Adventist Health policies and that any violation may result in corrective and/or disciplinary action up to and including termination. Adventist Health reserves the right to modify these policies at its sole discretion.

Signature

Date

Attachment 2

NOTICE

(To be distributed to all Billing Employees)

**ADVENTIST HEALTH
HOSPITAL PATIENT BILLING
COMPLIANCE PROGRAM
A Personal Commitment to Integrity**

It is and has always been the policy of Adventist Health (“AH”) to fully comply with all laws, regulations and ethical requirements that apply to health care providers. To help ensure that AH and all AH employees continue to comply with these standards, AH has adopted a Hospital Patient Billing Compliance Program which formalizes our compliance efforts into a comprehensive program which better defines the responsibilities of all AH employees regarding patient billing compliance issues.

AH’s Hospital Patient Billing Compliance Program reflects AH’s strong commitment to comply with all laws and regulations affecting it’s Patient Financial Services operations.

Each AH-affiliated patient financial services department will receive a copy of the Hospital Patient Billing Compliance Program. In addition, a training and education program will help ensure that patient financial services department employees understand the standards of conduct that they are expected to follow.

The Hospital Patient Billing Compliance Program is designed to *prevent* violations of applicable laws, regulations, policies and ethical requirements by helping employees choose the proper course of action when faced with difficult compliance issues. Specifically, the Compliance Program emphasizes training and encourages employees to seek advice whenever they are uncertain as to the proper course of action to take. An employee’s supervisor, local director, local facility compliance officer, and the Corporate Compliance Officer are always available to help answer any questions an employee may have concerning compliance issues.

The Hospital Patient Billing Compliance Program is also designed to *detect and correct* violations of applicable laws, regulations, policies and ethical requirements. Therefore, it is the duty and responsibility of each employee to report promptly to an appropriate person any violation or potential violation of these standards.

The preferred method of reporting or communicating potential compliance issues or anything that may otherwise compromise the integrity of AH is for an employee to first try to speak to his or her supervisor directly. This is consistent with AH’s “open-door” policy. However, in certain situations, an employee may feel uncomfortable discussing a particular situation with his or her supervisor. Therefore, each employee is free to discuss or report any suspected misconduct or non-compliance to their local director, local facility compliance officer, or the Corporate Compliance Officer.

In addition, AH established a toll free telephone number, 1-888-366-3833, through which employees may submit confidential, and if desired, anonymous, reports. This reporting procedure allows employees to report suspected misconduct or non-compliance by bypassing normal channels of communication and chains of command. Suspected misconduct and non-compliance issues may also be reported through written reports. Compliance reporting forms are available from various locations in your facility, through the human resource department and/or local compliance officer. To make a written report you may write to your local compliance officer or AH's Corporate Compliance Officer at the addresses below.

Employees are encouraged to identify themselves when making such reports so that the information can be investigated promptly and thoroughly. However, any report may be made on an anonymous basis. In addition, *no employee will suffer any penalty or retribution for reporting suspected misconduct or non-compliance.*

All such reports will be relayed to local compliance officer for investigation. Any AH employee who is found to have engaged in conduct on behalf of the company in violation of the Hospital Patient Billing Compliance Program may be subject to prompt and appropriate discipline, up to and including dismissal.

Feel free to contact, verbally or in writing, the following with any questions or concerns you may have about the application of any law, regulation or company policy to your organization, or any suspected violation of law, company policy or Hospital Patient Billing Compliance Program.

[Local Compliance Officer]

[Facility]

[Address]

[City], [State] [Zip]

Tel: (xxx) xxx-xxxx

Fax: (xxx) xxx-xxxx

Corporate Compliance Officer

Adventist Health

2100 Douglas Boulevard

P. O. Box 619002

Roseville, CA 95661-9002

Tel: (916) 781-4730

Fax: (916) 774-332

Attachment 3

[This is designed to be printed on a half sheet of 8 ½ x 11 paper and posted in the HIM Department for a reminder to employees of their reporting options.]

Adventist Health Compliance Program Reporting Compliance Concerns

Adventist Health supports and encourages each employee to maintain individual responsibility for monitoring and reporting any activity by any employee or contractor that appears to violate any applicable laws, rules, regulations or this Compliance Program. Adventist Health's self-monitoring compliance program provides a confidential reporting system with the following options available for handling your Compliance Program concerns:

- **Supervisor**
- **Local Compliance Officer**- Currently the Local Compliance Officer is [*INSERT NAME OF LOCAL COMPLIANCE OFFICER*], who can be reach at (____ - ____ - ____).
- **Compliance Report Form**- The forms are available from various locations in your facility, your human resource department, and your Local Compliance Officer.
- **Hotline**- A special toll-free telephone line is dedicated to reporting Compliance Program concerns. Please be prepared to provide details of the situation. The toll-free number is 1-888-366-3833 (Operators are available 8 a.m. to 5 p.m. Pacific Time, Monday-Thursday; 8 a.m. to 3:30 p.m. Pacific Time, Friday. Messages may be left during weekends and after-hours).
- **Corporate Compliance Officer**- Adventist Health, P. O. Box 619002, Roseville, CA 95661-9002.

Adventist Health
Corporate Compliance Program
Part 6: Patient Financial Services (PFS)
Checklist

Actions relating to the Compliance Program Specifically:

- _____ Review the compliance program with PFS personnel annually.
- _____ Distribute the notice entitled, “A Personal Commitment to Integrity” to each employee.
- _____ Obtain signed “Acknowledgement of Receipt and Review” from each employee.
- _____ Post the “Reporting Compliance Concerns” in a location each employee can view periodically.
- _____ Have the “Compliance Report” form available where employees can pick it up anonymously. These should be available so that employees can use them to report compliance concerns.

Actions required by the Compliance Program Concerning Operations:

Standards of Conduct:

- _____ Requires each employee to report fraud, waste, abuse, and/or unethical activity.
- _____ Staff must comply with pertinent government regulations.
- _____ Staff should seek advice when they are uncertain about the proper course of action.

Billing:

- _____ The department will assist in communication changes in medical necessity standards as published by fiscal intermediaries and CMS to health care professionals and various departments.
- _____ Policies and procedures will ensure that claims submitted are only for medically necessary services.
- _____ Policies and procedures will help prevent billing for duplicate services.
- _____ Policies and procedures will help ensure that services are bundled and unbundled appropriately.
- _____ The department will work collaboratively with other departments to ensure the charge description master (CDM) is properly maintained.
- _____ The department will work collaboratively with the IS department to ensure that billing editors are properly maintained.
- _____ The department will assist in establishing policies and procedures that identify outpatient services provided 3 days prior to an inpatient admission for inclusion in the IP claim.
- _____ Credit Balances must be promptly refunded.
- _____ The department will establish policies to ensure that Medicare bad debts are handled properly.
- _____ Department procedures will help ensure claims are submitted with appropriate ICD-9 codes.
- _____ The department will review claim denials and take corrective action as necessary.

Adventist Health
Corporate Compliance Program
Part 6: Patient Financial Services (PFS)
Checklist

_____ Policies will be established to ensure the proper use of modifiers.

_____ Policies and procedures will be established regarding the waiver of deductibles and coinsurance.

Compensation to Billing Staff and consultants:

_____ Compensation must not be in a method that encourages erroneous submission of claims.

Training and Education:

_____ All PFS personnel must be knowledgeable about those regulations affecting their responsibilities.

Audits:

_____ The department will participate in periodic claims audits.

_____ The department will periodically participate in audits to determine that discharges and transfers are billed properly.

OIG Fraud Alerts

_____ Each AH Agency must comply with the applicable OIG Fraud Alerts that are periodically published on the OIG web site.

Attachment 2

NOTICE

(To be distributed to all Billing Employees)

**ADVENTIST HEALTH
HOSPITAL PATIENT BILLING
COMPLIANCE PROGRAM
A Personal Commitment to Integrity**

It is and has always been the policy of Adventist Health (“AH”) to fully comply with all laws, regulations and ethical requirements that apply to health care providers. To help ensure that AH and all AH employees continue to comply with these standards, AH has adopted a Hospital Patient Billing Compliance Program which formalizes our compliance efforts into a comprehensive program which better defines the responsibilities of all AH employees regarding patient billing compliance issues.

AH’s Hospital Patient Billing Compliance Program reflects AH’s strong commitment to comply with all laws and regulations affecting it’s Patient Financial Services operations.

Each AH-affiliated patient financial services department will receive a copy of the Hospital Patient Billing Compliance Program. In addition, a training and education program will help ensure that patient financial services department employees understand the standards of conduct that they are expected to follow.

The Hospital Patient Billing Compliance Program is designed to *prevent* violations of applicable laws, regulations, policies and ethical requirements by helping employees choose the proper course of action when faced with difficult compliance issues. Specifically, the Compliance Program emphasizes training and encourages employees to seek advice whenever they are uncertain as to the proper course of action to take. An employee’s supervisor, local director, local facility compliance officer, and the Corporate Compliance Officer are always available to help answer any questions an employee may have concerning compliance issues.

The Hospital Patient Billing Compliance Program is also designed to *detect and correct* violations of applicable laws, regulations, policies and ethical requirements. Therefore, it is the duty and responsibility of each employee to report promptly to an appropriate person any violation or potential violation of these standards.

The preferred method of reporting or communicating potential compliance issues or anything that may otherwise compromise the integrity of AH is for an employee to first try to speak to his or her supervisor directly. This is consistent with AH’s “open-door” policy. However, in certain situations, an employee may feel uncomfortable discussing a particular situation with his or her supervisor. Therefore,

each employee is free to discuss or report any suspected misconduct or non-compliance to their local director, local facility compliance officer, or the Corporate Compliance Officer.

In addition, AH established a toll free telephone number, 1-888-366-3833, through which employees may submit confidential, and if desired, anonymous, reports. This reporting procedure allows employees to report suspected misconduct or non-compliance by bypassing normal channels of communication and chains of command. Suspected misconduct and non-compliance issues may also be reported through written reports. Compliance reporting forms are available from various locations in your facility, through the human resource department and/or local compliance officer. To make a written report you may write to your local compliance officer or AH's Corporate Compliance Officer at the addresses below.

Employees are encouraged to identify themselves when making such reports so that the information can be investigated promptly and thoroughly. However, any report may be made on an anonymous basis. *In addition, no employee will suffer any penalty or retribution for reporting suspected misconduct or non-compliance.*

All such reports will be relayed to local compliance officer for investigation. Any AH employee who is found to have engaged in conduct on behalf of the company in violation of the Hospital Patient Billing Compliance Program may be subject to prompt and appropriate discipline, up to and including dismissal.

Feel free to contact, verbally or in writing, the following with any questions or concerns you may have about the application of any law, regulation or company policy to your organization, or any suspected violation of law, company policy or Hospital Patient Billing Compliance Program.

[Local Compliance Officer]

[Facility]

[Address]

[City], [State] [Zip]

Tel: (xxx) xxx-xxxx

Fax: (xxx) xxx-xxxx

Corporate Compliance Officer

Adventist Health

2100 Douglas Boulevard

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Adventist Health Compliance Program Reporting Compliance Concerns

Adventist Health supports and encourages each employee to maintain individual responsibility for monitoring and reporting any activity by any employee or contractor that appears to violate any applicable laws, rules, regulations or this Compliance Program. Adventist Health's self-monitoring compliance program provides a confidential reporting system with the following options available for handling your Compliance Program concerns:

- **Supervisor**
- **Local Compliance Officer**- Currently the Local Compliance Officer is [*INSERT NAME OF LOCAL COMPLIANCE OFFICER*], who can be reach at (____-____-____).
- **Compliance Report Form**- The forms are available from various locations in your facility, your human resource department, and your Local Compliance Officer.
- **Hotline** - A special toll-free telephone line is dedicated to reporting Compliance Program concerns. Please be prepared to provide details of the situation. The toll-free number is 1-888-366-3833 (Operators are available 8 a.m. to 5 p.m. Pacific Time, Monday-Thursday; 8 a.m. to 3:30 p.m. Pacific Time, Friday. Messages may be left during weekends and after-hours).
- **Corporate Compliance Officer**- Adventist Health, P. O. Box 619002, Roseville, CA 95661-9002.

Adventist Health
Corporate Compliance Program
Part 7: Hospital Based Clinics
Checklist

Actions relating to the Compliance Program Specifically:

- _____ Review the compliance program with clinic staff annually.
- _____ Distribute the notice entitled, “A Personal Commitment to Integrity” to each employee.
- _____ Obtain signed “Acknowledgement of Receipt and Review” from each employee.
- _____ Post the “Reporting Compliance Concerns” in a location each employee can view periodically.
- _____ Have the “Compliance Report” form available where employees can pick it up anonymously. These should be available so that employees can use them to report compliance concerns.

Actions required by the Compliance Program Concerning Operations:

Standards of Conduct:

- _____ Requires each employee to report fraud, waste, abuse, and/or unethical activity.
- _____ Staff must comply with pertinent government regulations.
- _____ Staff should seek advice when they are uncertain about the proper course of action.

General Policies and Procedures:

- _____ AH facilities do not pay for referrals.
- _____ Compensation arrangements with referral sources must comply with the AH Referral Source Compliance Program requirements.
- _____ Physicians and other licensed health care professionals are responsible for patient care.
- _____ AH management and employees will assist physicians and other licensed professionals as they document services and refer patients in a manner that is appropriate and necessary for the patient’s medical condition. They will bring to the providers’ attention deficiencies and/or errors in a responsible manner.
- _____ Policies and procedures will be structured to comply with any Corporate Practice of Medicine restrictions.

Billing:

- _____ Billed claims will be honest, accurate, and complete.
- _____ Policies and procedures will ensure that claims submitted are only for medically necessary services.
- _____ False statements involving billing and coding by physicians or employees will not be tolerated.
- _____ CPT & HCPCS codes must accurately describe the services ordered and performed.

Compensation to Subcontracted Billing Services:

- _____ Subcontracted billing services will abide by the same billing and coding standards applicable to AH employees and health care professionals.

Adventist Health
Corporate Compliance Program
Part 7: Hospital Based Clinics
Checklist

- _____ Compensation must not be in a method that encourages erroneous submission of claims.
- _____ The third-party billing services' compliance program will be reviewed and approved by the local compliance officer and legal counsel (as necessary).

Medical Records and Confidentiality:

- _____ The hospital based clinic will abide by state and federal requirements regarding confidentiality.
- _____ Confidential patient information should not be disclosed so as to violate patient rights.

Graduate Medical Education Teaching Programs:

- _____ Employees and contracted health professionals must know and comply with all applicable rules associated with graduate medical education programs.

Marketing

- _____ The entity must ensure that all marketing is honest, straightforward, informative, and non-deceptive and that staff and contracted agencies involved in marketing are properly trained concerning such activities.

Conflict of interest:

- _____ Employees and contracted physicians must avoid any actions that may appear as or involve a conflict of interest.
- _____ Conflicts of interest must be disclosed to the local compliance officer

Government Investigations:

- _____ AH facilities will comply with the law and cooperate with any reasonable demand made in a government investigation.
- _____ The local compliance officer must be notified of any government investigation to ensure AH, its employees, and contracted physicians are properly represented.

**PRIVILEGED AND CONFIDENTIAL
ATTORNEY-CLIENT COMMUNICATION
ATTORNEY WORK PRODUCT**

September 13, 1999

**ADVENTIST HEALTH
Corporate Compliance Program**

PART 7: Hospital Owned Physician Clinics

INTRODUCTION

Adventist Health (“AH”) has established the following policies and procedures for the hospital owned physician clinics in its effort to ensure compliance with applicable state and federal laws.

This Part 7 of the Compliance Program establishes AH’s policies and procedures regarding compliance with laws specific to hospital owned physician clinics. These policies and procedures are intended to assure that AH-affiliated hospitals and their agents and employees comply with applicable laws, regulations, government manual provisions and other government pronouncements that relate to hospital owned physician clinics.

While these policies and procedures highlight federal and state laws specific to hospital owned physician clinics, they do not include every legal requirement that applies to hospital owned physician clinics. Thus, each AH organization must ensure that its hospital owned physician clinic is in compliance with all laws, regulations and other applicable federal and state government pronouncement.

I.

INTENT

The following policies and procedures are a component of the Compliance Program. These policies and procedures reflect AH’s strong commitment to ethical behavior and to comply with all laws and regulations affecting its hospital owned physician clinic operations.

Each AH-affiliated hospital owned physician clinic will receive a copy of these policies and procedures. In addition, a training and education program will help ensure that physicians and employees understand the standards of conduct that they are expected to follow.

These policies and procedures are designed to *prevent* violations of applicable laws, regulations, policies and ethical requirements by helping physicians and employees choose the proper course of action when faced with difficult compliance issues. Specifically, these policies and procedures encourage physicians and employees to seek advice whenever they are uncertain as to the proper course of action. The physician’s and employee’s supervisor, local director, medical group

Board Adopted September 13, 1999

administrator, local compliance officer, and AH's Corporate Compliance Officer are always available to help answer any questions that may arise concerning compliance issues.

These policies and procedures are also designed to *detect and correct* violations of applicable laws, regulations, policies and ethical requirements. Therefore, it is the duty and responsibility of each physician and employee to report promptly any violation or potential violation of these standards to the appropriate person.

II.

POLICIES AND PROCEDURES FOR HOSPITAL OWNED PHYSICIAN CLINICS

A. Standards of Conduct.

AH does not tolerate fraud and abuse by its agents or employees. Accordingly, it is AH's express intention that each and every hospital owned physician clinic employee and physician prevent, discourage, and/or halt any such fraud, waste, and abuse or unethical activity discovered. Any activity that violates this policy must be reported immediately to the facility compliance officer assigned to that hospital owned physician clinic.¹

Moreover, AH encourages and expects adherence to all guidelines and regulations governing federally funded health care programs, as distributed from time to time by the hospital's fiscal intermediary/carrier or other government agency (e.g., new billing procedures, fraud alerts, etc.).

B. General Policies and Procedures

AH is committed to complying with all applicable laws. When the application of a law is uncertain, AH will seek guidance from consultants and/or legal counsel. Although it is not practical to list all laws to which AH and its affiliates are subject, the following are examples of the more common laws subject to hospital owned physician clinics:

¹ Such reports may be made verbally to the supervisor, local director, local facility compliance officer for that hospital owned physician clinic, the toll-free compliance hotline, 1-888-366-3833, or in writing, by mail or fax, to the local facilities' compliance officer. Please clearly indicate on the report if anonymity is desired.

1. **Referrals.**

AH does not pay or offer to pay anyone for referrals, including employees, physicians, or other health professionals. AH only pays for services provided to AH or its affiliated practices. AH does not make payments or provide non-cash benefits (e.g. office space) to any physician or other health professional for providing services to AH without a written contract that has been approved through the corporate approval process. (*See also Guidelines and Procedures for Physician and Other Referral Source Arrangements*).

AH practitioners or employees may be in a position to make referrals. Such referrals shall be based solely on what is deemed appropriate for the patient and in accordance with hospital and IPA contractual arrangements, and without regard to the number of referrals any physician or other health professional has made to AH.

AH does not pay patients for coming to AH facilities for health care services. AH does not provide gifts or bonuses, waive insurance copayments or otherwise provide financial benefits to patients in return for patient business for AH affiliates. Under certain circumstances, AH affiliates may provide appropriate financial accommodation (such as allowing monthly payments over time) to patients based purely on the financial need of the patient. It is an appropriate industry practice for physicians to distribute free drug samples to a patient. In addition, under certain circumstance a patient may be paid for participation in drug studies, focus groups, research studies or other performance improvement activities.

2. **Patient Care.**

The primary goal of AH's hospital owned physician clinics is to provide high quality, cost-effective health care services to patients. It is the duty and affirmative responsibility of all AH employees and contractors to be aware of and respond to deficiencies or errors in their health care services. Within the medical practice, physicians or other categories of licensed health care practitioners will be responsible for patient care, as appropriate to their licensing. No AH policy is intended or should be interpreted to discourage or prohibit AH health professionals from discussing treatment options or providing other medical advice or treatment deemed appropriate by such health professionals.

AH expects its management and employees to assist AH physicians and other health care practitioners as they document services provided and refer patients in a manner that is both appropriate and necessary for the patient's medical condition, as well as complying with contractual obligations.

It is the policy of AH to comply with all state and federal regulations governing a patient's right to have access to health care services with reasonable promptness and in a manner that assures continuity of care. AH is also committed to full compliance with any government agency requirements for standard grievance procedures and resolutions. Each AH hospital owned physician clinic is responsible for implementing and maintaining policies and procedures that ensure appropriate and accurate documentation of services provided.

3. **Corporate Practice of Medicine.**

AH hospital owned physician clinics provide medical services in a number of different states, each of which regulates the practice of medicine. In certain states, AH is not authorized or qualified to engage in any activity which constitutes the practice of medicine, and in such states, AH may not control or direct the professional medical judgment of its contracted health professionals or the methods by which such health professionals perform professional medical services. AH is committed to ensuring that its structure and operations comply with any applicable corporate practice of medicine restrictions, and expects all of its employees and contracted health professionals to comply with all such restrictions.

4. **Billing and Coding.**

AH bills only for services rendered. AH and its affiliates must comply with special billing requirements for government-sponsored programs and other payors. All AH physicians and employees must exercise care in any written or oral statement made to any government agency or other payor. AH will not tolerate false statements by AH physicians or employees to a government agency or other payor.

a. **Billing for Services.** In providing healthcare services, AH or its affiliates bills the patient or an insurance company, which may be the government. All insurance companies, as well as the government, have strict billing requirements that require our billing claims to be honest, accurate, complete and fully comply with the law.

AH is committed to full compliance with all rules and regulations of the Medicare, Medicaid, CHAMPUS and other federal and state health care programs, as well as the contractual requirements. AH bills for services honestly and accurately. All claims must accurately reflect the documented services provided, and only services that have accurate and adequate supporting documentation in the patient's medical record are billed. Late entries or marginal notes in medical records must be noted or explained. AH physicians and employees will apply the correct Current Procedural Terminology (CPT-4) and International Classification of Disease (ICD-9-CM) coding principles and guidelines when analyzing medical records documentation. Appropriate documentation will be maintained and will be available for audit if necessary. For additional information, refer to the policies and procedures for billing and coding of the AH affiliated entity.

It is both illegal and unethical to:

- Bill for items and services that were not ordered and performed
- Bill for items and services that are not medically necessary for the diagnosis or treatment of a patient, or are provided at a higher level of service than medically necessary
- Inappropriately unbundling or fragmenting services
- Double-bill services (such as billing for both calculations and the tests that are performed to derive such calculations)
- Overutilize unlisted procedure codes or miscellaneous diagnosis codes

- Upcode (selecting a code to maximize reimbursement when such code is not the most appropriate descriptor of the service provided)
- Fabricate diagnostic information
- Knowingly rely on invalid or outdated standing orders

b. **Subcontracts for Billing Services.** Subcontractors or independent contractors hired by AH for billing services become "agents" for AH and act in the "shoes" of AH employees, directors, and officers while performing their billing duties. It is therefore necessary that these individuals and entities adhere to the same billing and coding standards applicable to AH employees and contracted health professionals.

It is critical that any subcontractors engaged to perform billing services have the necessary skills, processes, systems and appropriate procedures to ensure that all billings for government and commercial insurance programs and private payers are accurate and complete. At a minimum, any subcontractors must have implemented policies and procedures to ensure that bundling /unbundling, DRG creep (i.e., the abuse of DRGs that result in a higher level of reimbursement), miscoding, coding for services not rendered, and double billing do not occur and that proper documentation exists to verify the amounts billed. Moreover, any incentive arrangements for subcontractors to "maximize reimbursement" are expressly prohibited.

All proposed third party billing contractors and their internal compliance programs should be reviewed and approved jointly by the local compliance officer and may include legal counsel.

5. **Medical Records and Patient Confidentiality.**

AH and its health professionals must collect information about patient medical condition, history, medication and family illnesses to provide the best possible care. This information is to be considered confidential and not released or discussed with others unless there is a specific 'need to know' basis in order to serve the patient, and in accordance with AH facility policies and procedures. AH employees and contracted health professionals are expected to comply with all federal and state laws applicable to the confidentiality and privacy of patient information. Employees and contracted health professionals should never disclose confidential information that violates the privacy rights of patients.

Patients are entitled to expect both the protection of confidentiality and the release of information only to authorized parties who have obtained the patient's written consent to inspect their medical records. In an emergency situation, when requested by an institution or physician, the patient's consent is not required, but you must verify the name of the institution and the person requesting the information.

6. **Graduate Medical Education Teaching Programs.**

AH is committed to graduate medical education programs, including medical residency and fellowship programs. For those residency practices, it is the duty of all employees and contracted health professionals to understand and comply with all applicable rules and requirements associated with graduate medical education programs. AH is committed to full compliance with all laws and regulations applicable to the Medicare, Medicaid, CHAMPUS and other federal and state health care programs, as well as the contractual requirements of all commercial insurance programs.

Appropriate policies and procedures are to be implemented to ensure that there are clear written statements regarding billing for physician services in a teaching setting, as well as to provide detailed guidance on issues of general interest such as the teaching physician rule.

7. **Marketing and Advertising.**

AH will not make any unethical or illegal payments to anyone to induce the use of our services. An AH employee or contracted health professional should never make a payment which, if it were publicly disclosed, would embarrass AH. To avoid the appearance of impropriety, AH will not provide any payment or reimbursement for expenses incurred by any government representative or employee. AH also will not provide gifts or payment of any kind to or on behalf of any government representative or employee. AH will not tolerate the making of such payments.

All AH advertising must be truthful and not misleading. Specific claims about the quality of AH's services must be supported by evidence to substantiate the claims made. All price advertising by AH affiliates must accurately reflect the true charge for services provided to patients. AH does not use advertisements or marketing programs which might cause confusion between our services and those of our competitors. AH does not disparage the service or business of a competitor through the use of false or misleading representations.

8. **Conflicts of Interest.**

Each AH physician or employee has a duty of loyalty to AH, and must avoid any actions that may involve, or may appear to involve, a conflict of interest with their obligations to AH. Similarly, each contracted health professional has a duty of loyalty to his or her medical practice, and must avoid any actions that may involve, or may appear to involve, a conflict of interest with their obligations to the medical practice or AH. For additional information on this subject, refer to the AH policies and procedures for conflicts of interest.

a. **Competitors.** AH employees should not own stock in, serve as corporate director or corporate officer of, receive compensation from, or provide consulting or other services to physician practice management companies or other firms in competition with AH in the health care industry without the written consent of their supervisor. However, AH employees may own less than one percent of the outstanding shares of any class of equity security of a competitor or supplier listed on a national securities exchange or regularly traded in the over-the-counter market.

b. **Suppliers.** AH employees and contracted health professionals who deal with suppliers must do so in a reputable, professional, and legal manner. AH employees and contracted health professionals should decline gifts, including discounts, the acceptance of which would raise the issue of improper influence. Discounts that are available to all AH employees and contracted health professionals may be accepted.

c. **Business Information.** AH has developed or owns certain confidential information that it wants or needs to protect. Some examples of this type of information include personnel data, patient lists, financial data, research data, clinical information, strategic plans and potential mergers and acquisitions, marketing strategies, processes, techniques, computer software and any information with a copyright, financial results or other business dealings.

Although AH physicians and employees may use this confidential information to perform their jobs, it is not public information. Generally, AH physicians or employees should not discuss this type of information with anyone outside of AH, and only share such information on a strictly 'need to know' basis with other employees or contracted health professionals who require this information to perform their jobs, unless expressly authorized by AH. AH employees and contracted health professionals may not use for their personal benefit any information about AH or information acquired as a result of their relationship with AH. Violation of this policy may result in personal liability to the employee or contracted health professional for any benefit gained from improper use of such information or any damages sustained by AH as a result of improper disclosure of such information.

d. **Disclosure of Possible Conflicts of Interest.** A conflict of interest may occur if an AH physician's or employee's outside activities or personal interests influence or appear to influence their ability to make objective decisions in the course of their job responsibilities. A conflict of interest may also exist if the demands of any outside activities hinder or distract an employee or physician from the performance of their job or cause them to use AH resources (i.e. time, computers,

facilities, supplies) for non-AH purposes. It is important that while on the job, all AH employees think about AH first and their personal business interests remain separate.

Employees and contracted health professionals should disclose possible conflicts of interest involving themselves or their immediate family members (spouse, parents, brothers, sisters, and children) to the local compliance officer. The local compliance officer will investigate and report possible conflicts to the Board of Directors. The Board of Directors will determine whether significant conflicts of interest do exist and take the necessary steps to protect AH.

All AH employees and contracted health professionals need to avoid any situation where a conflict of interest does exist or might appear to exist between his or her personal interests and those of AH. The *appearance* of a conflict may be as serious as an *actual* conflict of interest. Do not let any outside financial interest influence your decisions or actions taken on behalf of AH. There are many types of situations where potential conflicts may arise.

9. **Government Investigations.**

It is AH's policy to comply with the law and to cooperate with any reasonable demand made in a government investigation. In so doing, however, it is essential that the legal rights of AH and of the personnel involved be protected. If you receive an inquiry, a subpoena, or other legal document regarding AH business, whether at home or in the workplace, from any governmental agency, notify your supervisor or the local compliance officer immediately. The law guarantees all of us a right to be represented by legal counsel during any investigation or inquiry of any governmental agency. In view of the complex and technical nature of many government investigations, we feel that AH itself should be so represented and that all of our employees and contracted health professionals should at least be made aware of the opportunity for such representation. For additional information on this subject, refer to the AH policies and procedures for government investigations.

C. **Miscellaneous**

The policies and procedures established in this document are in addition to, and should be reviewed and distributed in concert with, the Corporate Compliance Program, Part 1. This Part 7 of the Compliance Program establishes AH's policies and procedures regarding compliance with laws and issues specific to hospital owned physician clinics, and therefore supplements the Corporate Compliance Program, Part 1. Furthermore, employee handbooks and all applicable AH policies and procedures should be followed.

Adventist Health Sanctioned Physicians, Employees, & Vendors Policies

Adventist Health established policies (see attached) to identify individuals who have been excluded from the government health care programs. Our policies and procedures address the following groups:

- Physicians/Health Care Providers
- Employees
- Vendors

Effective 2002, the Adventist Health Corporate Compliance Department generates reports two times a year that compare physicians, employees, and vendors to the government databases. The reports list the names of individuals that are excluded from the government health care programs that match names from our facility databases. It is the responsibility of each local compliance officer to have someone research the names listed on the reports to determine if the individuals or entities that we do business with are excluded from the government health care programs.

Additionally, each facility must establish procedures to screen new medical staff, employees and vendors to ensure our facilities do not do business with excluded individuals or entities. The following summarizes the procedures that should be performed:

Medical Staff: The medical staff credentialing department must screen all new medical staff applicants to determine whether the applicants are excluded from government health care programs (i.e., Medicare, Medicaid/Medi-Cal, Tricare, Federal Employees Health programs, etc.).

Human Resources: The HR department must establish procedures to screen new applicants. Each new employee applicant's name should be compared to the government databases. As a general rule our facilities should not hire or do business with individuals excluded from the government healthcare programs. There are rare instances where excluded individuals may work for a health care organization that does business with government health care programs. If you are faced with that situation, call the AH Corporate Compliance Department to discuss.

Accounts Payable/Materials Management: The accounting staff and materials management departments should establish procedures to check new vendors/supplies against the government excluded individual databases.

The searches may be performed by going to the OIG, GSA, and Medi-Cal excluded individuals websites as listed in the following system-wide sanction policies, or they may be performed by searching the combined OIG/GSA/Medi-Cal data base that the Compliance Department created on the AS400. Ask your regional ASA or the Compliance Department for directions on how to install those menu options.

Corporate Compliance Department

Charter

In furtherance of the Adventist Health Corporate Compliance Program, Adventist Health establishes the Corporate Compliance Department, to provide oversight to the Compliance Program. The responsibilities of the department are:

- Develop, expand, and coordinate the corporate compliance program.
- Monitor legislation involving compliance-related issues, such as, physician contracting, patient billing, coding, etc.
- Collect, review, and prepare physician contract information for presentation to Adventist Health's Board Compliance Committee.
- Establish, oversee, monitor, and maintain the internal corporate compliance reporting process to ensure Adventist Health employees and agents can report ethics and compliance concerns without fear of retaliation. Ensure reported concerns are promptly and thoroughly investigated. Periodically summarize reporting activities to the Corporate Compliance Officer for presentation to Adventist Health's legal board and/or its' appointed subcommittee.
- Participate in the communication, development of training material and programs to 1) convey Adventist Health's Code of Conduct to all employees, 2) periodically refresh employees' knowledge of the Code of Conduct, and 3) address areas of compliance risk concerning specific employee populations.
- Participate in the process of ensuring that internal control systems are capable of detecting significant instances or patterns of illegal or unethical conduct by employees or agents.
- Provide technical support and consultation to local compliance officers and interface with corporate counsel in determining appropriate responses to compliance violations.
- Provide consultative services to AH Affiliate patient financial services departments to promote compliance with regulatory requirements, and improve and enhance efficient billing operations.
- Provide technical support to Adventist Health Affiliate departmental managers by researching compliance related issues that affect their department operations.

The department shall be led by the "Director, Corporate Compliance" (Director), at the corporate offices of Adventist Health. The Director shall report to the Senior Vice President of Finance/Corporate Compliance Officer. The Director shall keep the Corporate Compliance Officer apprised of current activities and make periodic reports to the Adventist Health Legal Board regarding the status of the Compliance Program.

The Department shall meet its responsibilities by establishing and following annual goals and objectives designed to carry out the purposes of the Adventist Health Compliance Program. The departmental goals and objectives will include tangible measures designed to document the effectiveness of the department's endeavors. The Department shall establish such goals based on the requirements of the AH Corporate Compliance Program, issues raised at the various Adventist Health Affiliates, information and publications from governmental agencies, industry trade organizations, and corporate legal counsel.

The Department shall work with the Regional and Local Compliance Officers to support them in carrying out the Adventist Health Corporate Compliance Program in their local facilities. The Department shall monitor compliance related issues that affect various departments of Adventist Health Affiliates and communicate such issues to the AH Affiliate Departmental directors. The Department will work collaboratively with all Adventist Health departments that are impacted by the organization's compliance program (e.g., Budget/Reimbursement, Information Systems, Risk Management, Communications, etc.)

Emergency Medical Treatment And Active Labor Act
EMTALA
Anti-Dumping Laws

Federal laws regulate the way Adventist Health facilities treat patients who arrive at our emergency rooms for treatment. The Adventist Health Risk Management Department (Risk Management) oversees these issues within our system.

Risk Management developed a “Sample EMTALA Compliance Program” that each facility adopted. You may view and download the EMTALA Compliance Program on the Risk Management Intranet site at

<http://ahweb1.ah.org/RMCorporate/documents/EMTALA/EMTALAMasterDoc.pdf>

HHS Office of Inspector General (OIG)

Fraud Alerts

The government publishes guidance from time to time that addresses compliance issues they believe impact health care organizations. The following are some of the different publications the government uses to communicate their compliance issues:

Fraud Alerts

Bulletins

Other Guidance

Compliance Guidelines

Advisory Opinions

The next three pages are print outs of the HHS Office of Inspector General (OIG) Fraud Prevention & Detection web page, found at <http://oig.hhs.gov/fraud/fraudalerts.html>.

Following the web page print outs are copies of the OIG Fraud Alerts.

HHS Office of Inspector General (OIG)

Work Plan

Each year the OIG publishes a "Work Plan." Their work plans summarize the various areas that they will attempt to investigate and what they expect to achieve regarding those areas.

Attached is a copy of the most current "Work Plan." The pages included for your review are for:

Medicare Hospitals

Home Health

Hospice

Physicians

Medical Equipment

Laboratory Services

Other Medical Services

Adventist Health Human Resources

The Human Resource department's compliance role includes the following areas:

- Screen new applicants for sanctioned individuals
- Incorporate the 30 minute Code of Conduct education into the new employee orientation program
- Register and schedule new employees for the computer based compliance training program.
- Conduct terminating employee interviews. Exit interviews provide a good opportunity to inquire whether the terminating employee is aware of any compliance issues that need to be addressed by the organization.

If your facility does not conduct exit interviews the HR department should establish a procedure to send out a letter from the local compliance officer on facility letterhead, along with a "Compliance Report Form," that reminds the employees of the facility's compliance program. The letter asks the terminating employee to report any compliance issues that they may be aware of so the local compliance officer can ensure it is resolved appropriately.

Adventist Health Corporate Compliance Program Binder

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