

Corporate Compliance Program



Adventist Health Corporate Compliance Program Binder

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Adventist Health Compliance Program 2022 Overview

Overview: Adventist Health (AH) leadership are responsible for regulatory compliance of the organization. To help support AH's compliance efforts it established a corporate compliance program in 1996. Over a period of years the program developed and expanded to include various compliance risk areas, e.g., physician contracts, home health, laboratories, health information management, billing, hospital-based physician 1206(d) clinics, hospital-based physician 1206(l) clinics, Adventist Health Physicians Network, rural health clinics, patient identity protection (Red Flag Rules) HIPAA Privacy and IT Security. The primary focus of these distinct components is to ensure operations comply with their respective regulatory requirements.

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

Corporate Compliance: The compliance program is managed by the Adventist Health Corporate Compliance Department in Roseville, California. Kevin Longo, Chief Compliance Officer, Compliance & Privacy, reports to Meredith Jobe, General Counsel, and to the Legal Board's Risk/Compliance Committee. The Chief Compliance Officer oversees the Compliance & HIPAA Privacy programs from the Roseville Corporate Office. In addition, each facility has a designated Local Compliance Official, a HIPAA Privacy Official, and an IT Security Official who are responsible for managing the compliance program and HIPAA Privacy oversight in the local networks and markets.

The Corporate Compliance Department's responsibilities include:

- 1) manage the overall reimbursement compliance program,
- 2) manage the Adventist Health compliance reporting operations,
- 3) investigate reported violations, and
- 4) conduct monitoring and auditing activities to evaluate the effectiveness of the organization's compliance activities.

There are many regulatory matters that do not fall directly under the Compliance Department's responsibilities. The following is a brief description of individuals who are responsible for other significant risk areas:

- ePHI security issues are managed through the Incident Response Process by the AH Enterprise Technology Department's Information Security team, overseen by Bruce Chitester, Information Security Official.
- Vanessas Fraczek, Director, Clinical Risk provides oversight of clinical risk management.

- Julee Thomas, System Director, Risk and Insurance Services, provides oversight of insurance coverage, AH's self-funded health program, and medical malpractice matters.
- Amber Theel, Quality and Patient Safety Executive, provides leadership and oversight of matters affecting quality and patient safety.
- Jacalyn Leibowitz, System Chief Nursing Officer, provides oversight for nursing operations, regulatory matters affecting facility licensing and accreditation and clinical practice and education.
- Arby Nahapetian, M.D., Chief Clinical Officer, is responsible for clinical effectiveness and quality of care.
- Meredith Jobe, General Counsel, provides leadership and oversight of the AH Legal Department, AH legal affairs, Enterprise Risk Management, Compliance and Internal Audit.
- Joyce Newmyer, Chief People Officer, provides oversight of AH Human Performance matters.

Compliance Department Activities:

Maintains a Summary of the Compliance Program: The Adventist Health Internet site at <https://www.adventisthealth.org/pages/compliance-information.aspx> describes our compliance program and includes a copy of the compliance program, code of conduct and Local Compliance Official and Privacy Official contact lists. In addition, the "Compliance Report Form" link provides a form for use in reporting compliance related matters for investigation and follow purposes. This form may be emailed to the AH Compliance Department at corpcomp@ah.org.

Compliance Education: AH requires all employees to complete Code of Conduct training as well as corporate compliance training that is available through the HealthStream Learning Center (HLC). All AH employees are expected to complete the mandatory compliance training. New employees are required to complete AH's compliance training within 90 days of their hire date. "Affected" employees must complete compliance training every year. "Affected" employees are in specific roles responsible for one of the specific risk areas addressed in the AH compliance program.

Sanctioned Individuals: AH compares employees, volunteers, contingent workers, physicians, board members and vendors to the Department of Health and Human Services Office of Inspector General (OIG), U.S. General Service Administration (GSA) System for Award Management (SAM), and State Medi-Cal/Medicaid Sanction Lists excluded Providers sanctioned, debarred and ineligible databases each month. New hires are screened against the government exclusion databases during the background check. Physicians on the Medical Staff are screened during the credentialing process.

Referral Source Contract Approval Process: Each AH Facility is required to process physician contracts according to the AH System-wide Policy "Physician Arrangements Review" and AH System-wide Procedure "Physician Arrangements

Review Process.” Facility management is responsible for negotiating the contracts and obtaining a review and approval from the Physician Arrangement Review Team (PART) and Adventist Health Office of General Counsel.

Referral Source Contract Audits: Compliance department staff conduct audits of each facility’s referral source contracts. The purpose of these audits is to ensure that facilities are processing these contracts in accordance with Adventist Health policy and approval procedures. The audits involve all referral source contracts. Each hospital is audited once every two years.

Physician Payment Reviews: Compliance department staff conduct audits of all payments to physicians and referral sources, to ensure the payments are made according to a properly executed contracts. The department performs these audits on a quarterly basis.

Coding Audits: The Inpatient, Outpatient Ancillary, and Ambulatory Coding Compliance Teams are responsible for performing inpatient, outpatient, and professional coding audits routinely. These audits are conducted by internal and/or external coding auditors. These audits focus on high risk claims that government sources have identified as susceptible to abuse. Sources for identifying high risk areas include the OIG Work Plan, PEPPER data, government audits, RAC audits, and codes identified internally as problematic.

HIPAA Privacy Electronic Medical Record (EMR) Access Monitoring: The compliance department’s HIPAA Privacy team routinely monitors AH’s EMRs to identify inappropriate access of patient records. Inappropriate access is subject to discipline. The Privacy and Security Disciplinary Action Policy provides guidance for management when responding to the inappropriate access of patient records.

340B Monitoring and Auditing: The AH System Pharmacy team provides oversight of the 340B drug monitoring program. This part of the program is well defined and requires quarterly 340B Compliance Committees both at a system and market level. Each market performs routine probe sample audits of 340B drugs. Members of the system pharmacy team conduct additional audits to monitor for accuracy.

Miscellaneous Compliance Audits: The department works collaboratively with patient financial services, health information management, home care, other departments and consultants, as necessary, to conduct, from time-to-time, specialty audits and reviews to determine facility compliance with regulatory issues. Examples include:

- 1) Audits associated with reported compliance matters
- 2) Routine IRS code 501(r) audits
- 3) Medicare Secondary Payor compliance
- 4) Important Message audits

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 officials, or by mail to the corporate office. These options are described at www.AdventistHealth.org/Patient-Resources/Compliance-Information.

The compliance department logs all compliance and privacy 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.

HIPAA Privacy Breaches: The HIPAA Privacy Team works collaboratively with the IT Security Team and General Counsel when Privacy Breaches are identified to ensure they are properly investigated, resolved, and reported to the various regulatory agencies.

Compliance Policies: The compliance department works collaboratively with Administration, Patient Financial Services, Health Information Management departments, HIPAA Privacy and Security, Risk Management, and the AH Legal departments to ensure that Adventist Health Affiliates have system-wide policies available to comply with the numerous regulatory requirements AH is expected to follow. These policies can be found on AH's Connect Intranet page under the LuciDoc link.

The compliance department oversees AH's Non-Clinical Policy process. There are 23 System Non-Clinical Policy Review Teams that develop, review, and revise non-clinical policies (e.g., Compliance, Revenue Cycle, Finance, Grants, Mission, Supply Chain, IT, IT Security, etc.). Each team has a designated operational leader and subject matter experts. These teams recommend new, reviewed, and revised policies to the various administrative cabinets for approval. Upon approval by the cabinets, they are distributed to the local markets for adoption.

Clinical Policies have a separate well defined development, review, and revision process. All clinical policies are routed to the Clinical Cabinet for approval.

Compliance Resources Available to Adventist Health Facilities:

Outside counsel:

Latham & Watkins
Nossoman, LLP
Athene Law
Hooper, Lundy and Bookman, PC
Polsinelli
McDermott, Will, & Emory

Associations:

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

American Medical Group Association (AMGA):
<https://www.amga.org/>

California Hospital Association (CHA):

<http://www.calhospital.org/>

Health Care Compliance Association (HCCA):

<http://www.hcca-info.org/>

Healthcare Financial Management Association (HFMA):

<http://www.hfma.org/>

Medical Group Management Association (MGMA):

<http://www.mgma.com/>

Society of Corporate Compliance & Ethics (SCCE):

<https://www.corporatecompliance.org/>

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 Adventist Health 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 "Chief Compliance Officer" (CCO), at the corporate offices of Adventist Health. The CCO shall report to the General Counsel of AH and the System Board's Risk/Compliance Committee. The CCO shall keep the General Counsel and System Board apprised of current activities and make periodic reports to the Adventist Health System 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 Adventist Health 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 Adventist Health Affiliate Departmental directors. The Department will work collaboratively with all Adventist Health departments that are impacted by the organization's compliance program (e.g., Finance, Information Systems, Risk Management, Communications, etc.)

Corporate Compliance Department

Mission Statement:

The Corporate Compliance Department is a team of dedicated professionals helping fulfill the Adventist Health Mission by supporting ethical standards and practices throughout the organization's business units and functioning as consultants to advise facility management teams and 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 payers, and the general public to operate with the highest levels of quality and accuracy. The intended result being the elimination of billing errors and false claims. The Corporate Compliance Department will deliver superior advisory services to its key customers to implement policies, procedures, systems, and practices that will effectively and economically comply with regulatory requirements.

Key Stakeholders:

Adventist Health Board of Directors
Risk/Compliance Committee
Adventist Health Senior Leadership
General Counsel
Chief Compliance Officer

Key Internal Customers:

Local Compliance Officers
Market Executive Teams
Contract Specialists
Patient Financial Services Personnel
Ancillary/Clinical Personnel
Home Health/Hospice Directors and Personnel
Health Information Personnel
Human Resource Personnel
Risk Personnel
Medical Foundations
Physician Clinics

Key External Customers:

Hotline Reporting Parties
Outside Counsel
Ernst & Young (External Auditors)
Medicare Fiscal Intermediaries and Carriers
CMS and other Regulators
Consultants

ADVENTIST HEALTH
Corporate Compliance Program

PART 1: Compliance Standards, Policies and Procedures

WARNING! This document is the private property of Adventist Health 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 Adventist Health or one of its Affiliates without the written consent of the Corporate Compliance Officer. Independent contractors of Adventist Health 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 has established this Corporate Compliance Program (“Program”) for the employees and independent contractors (hereafter collectively referred to as “employees”) of Adventist Health and any organization controlled by Adventist Health (an “Adventist Health Affiliate”)¹ who is or may be involved in an activity governed by the Program (“affected employees”).

The Program has multiple parts. Part 1 sets forth a code of conduct, standards and procedures for all corporate activity. Part 2 sets forth contract guidelines and approval guidelines for an Adventist Health Affiliate to enter into an agreement with any physician or other person who refers business to the Adventist Health Affiliate. Part 3 sets forth guidelines for the operation of Adventist Health home health agencies and hospice programs. Part 4 sets forth guidelines for the operation of Adventist Health clinical laboratories. Part 5 sets forth guidelines for the clinical and diagnostic coding of Adventist Health patient records. Part 6 sets forth guidelines for the operation of Adventist Health patient billing offices. Part 7 sets forth guidelines for the operation of Adventist Health hospital based physician practices. Part 8 sets forth guidelines for the operation of Adventist Health Medical Foundations. Part 9 sets the guidelines for Adventist Health Rural Health Clinics. Part 10 sets for the guidelines for Patient Identity Theft Protection.

II.
PURPOSE OF ADVENTIST HEALTH

Adventist Health is a nonprofit, religious corporation that controls numerous provider organizations in the Western United States. Adventist Health’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. Adventist Health 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. Adventist Health 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.

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

III.
POLICIES AND PROCEDURES

A. Code of Conduct.

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

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.

Compliance Officers

AH shall appoint a Corporate Compliance Officer (CCO). In addition, the President of each AH Entity shall designate a local compliance officer (LCO) for such AH Entity. Each LCO 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 CCO and each LCO shall be responsible for implementing, overseeing and enforcing all aspects of the Program. A list of the current CCO and the LCOs is set forth in Attachment 1.3, which shall be updated as necessary.

The CCO shall coordinate with each LCO to uniformly implement the Program. All compliance officers will coordinate their activities with AH legal counsel (“Counsel”) as set forth in this Program.

The identity of each AH Entity’s LCO 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 complete online training through the HealthStream Learning Center summarizing this Program as described below.

Level of Authority:

To carry out the responsibilities of the Program, the CCO shall report to the Chief Executive Officer (CEO) of Adventist Health, with direct access to the Legal Board, and the Board Compliance Committee. The LCOs will report directly to their entity’s CEO and will have access to the Legal Board and Board Compliance Committee through their reporting relationship to the CCO.

The Entity’s Legal Board and CEO will provide the CCO with the funding and staff necessary to adequately implement and operate the Program.

Access to Documents and Individuals:

For auditing and monitoring purposes, the CCO and LCOs will have access to the following documents:

1. Patient records
2. Billing records
3. Records concerning AH Entity marketing activities
4. Records consisting of arrangements with other parties, including employees, home health agencies, all ancillary services, professionals on staff, independent contractors, suppliers, agents, supplemental staffing entities and physicians, and
5. Any other documentation reasonably necessary to achieve the goals of this Program.

D. Specific Duties of the Compliance Officers

1. **Duties of the CCO:**
 - a. Overseeing and monitoring the implementation and maintenance of the Program.
 - b. Know and understand all aspects of the Program;
 - c. Ensure that the day-to-day operations of the Program are performed.
 - d. To insure 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;
 - e. 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 impractical;
 - f. To bring to the attention of AH CEO and Counsel all changes in circumstances which could reasonably suggest that the Program should be modified;
 - g. Log, track and respond appropriately and timely to all reported facility compliance reports. Investigations will be designed on a case-by-case basis and conducted with guidance from the Counsel as necessary.
 - h. Be responsible for working with the Local Compliance Officers to ensure that all compliance program evaluations and audits are routinely conducted and that all recommendations are properly addressed. Examples include the Compliance Program Reviews, Contract Audits, Physician Payment Reviews, Non-Monetary Compensation Reviews, Charge to Chart Audits, Coding Audits, Important Message Audits, etc.
 - i. Maintain periodic reports summarizing the compliance activities conducted by AH and its entities.
 - j. Ensure that the mandatory compliance education is completed by all affected employees according to AH's System-wide Code of Conduct and Fraud Awareness Training policy AH-09-003-S.

- k. Report periodically to the CEO, Legal Board, and Board Compliance Committee regarding the operations of the Program and significant developments.
- 2. Duties of the LCO:**
- a. Know and understand all aspects of the Program policies and procedures;
 - b. Manage the local facility's day-to-day operations of the Program.
 - c. Manage the local compliance committee.
 - d. Consult with the CCO and Counsel to obtain interpretations of any requirements under the Program which are unclear, vague or which the LCO believes to be void, outdated or impractical.
 - e. Bring to the attention of the CCO and Counsel all changes in circumstances which require Program modification.
 - f. Log, track and respond appropriately and timely to all reported facility compliance reports. Investigations will be conducted with guidance from the CCO and Counsel as necessary.
 - g. Be responsible for ensuring that all compliance program evaluations and audits are routinely conducted and that all recommendations are properly addressed at their local facility. Examples include the Compliance Program Reviews, Contract Audits, Physician Payment Reviews, Non-Monetary Compensation Review, Charge to Chart Audits, Coding Audits, Important Message Audits, etc.
 - h. Ensure that all compliance program responsibilities that are delegated to the various departments are carried out appropriately and timely (See Exhibit 1.7).
 - i. Ensure that independent contractors and agents who provide services (e.g., billing companies, coding consultants, delivery services, and referral sources) to the Facility are receive information regarding the requirements of Facility's Program with respect to Health Insurance Portability and Accountability Act of 1996 (HIPAA), coverage, billing, marketing, and kickbacks, among other things.
 - j. Work with the AH Corporate Compliance Department to maintain periodic reports of the hospital's compliance activities, at a minimum annually.
 - k. Ensure that the mandatory compliance education is completed by all affected employees according to AH's System-wide Code of Conduct and Fraud Awareness Training policy AH-09-003-S.
 - l. Report periodically to the hospital CEO and CCO regarding the operation of the Program and significant developments.
 - m. Carry out other duties as assigned by the CCO and/or the local CEO.

E. Local Compliance Committee

Each AH facility shall establish a local compliance committee. The role of the local compliance committee is to provide executive oversight of the regulatory risk areas affecting facilities. The committee' oversight responsibilities include reimbursement, privacy, CMS conditions of participation and state licensing. The local compliance officer, facility privacy official, and director of risk management are typically responsible for facility operations designed to mitigate these three broad compliance risk areas. These individuals are responsible for the development, implementation, and oversight of the regulatory compliance program operations. The committee will actively participate in the compliance risk assessment and mitigation processes to include risks identification, prioritization of risks, assignment of risks to "owners," development of risk mitigation plans, ongoing risk monitoring, and over-all engagement in the risk management process. It is also responsible for ensuring that there are risk-driven internal controls throughout the organization to monitor compliance risks.

The members of the local compliance committee will consist of the Chief Executive Officer, (CEO), Chief Financial Officer (CFO), Patient Care Executive PCE, VP of Outpatient Services, Local Compliance Officer (LCO), Facility Privacy Official (FPO), Risk Manager, and others the local executive team consider necessary. The composition of the local compliance committee may be modified to meet the needs of the local facility. The committee may delegate some or all of the responsibilities to qualified subcommittees.

It shall meet at least on a quarterly basis.

The duties of the local compliance committee will include:

- Periodically assess facility operations to ensure newly identified compliance risk areas are evaluated, and all necessary internal controls are implemented to address the identified risks.
- Review corrective action plans to ensure that they are relevant, appropriate, and reasonably address the identified matter.
- Monitor and review the compliance reporting matrixes to ensure the facility is meeting its goals.
- Approve all regulatory associated policies and procedures.

1. Regulatory/Reimbursement Compliance:

Review all compliance audit reports and the facility responses to ensure all identified issues are properly resolved on a timely basis. These reports include:

- Compliance Program Reviews (risk assessments)
- Physician Contract Audits
- Physician Payment Audits
- Quarterly Coding Audits
- Quarterly Billing Audits (Charge-to-Chart Audits)

- Medicare Secondary Payer Audits
- Important Message Audits
- Internal & External Investigation Special Audits
- Charge Description Master audits
- Other audits involving billing, coding, charges, operational compliance activities.

Review the status of all compliance related cases, including all hotline reports, internal and external investigations to ensure they are resolved appropriately and on in a timely manner.

2. HIPAA Privacy and Security:

Review the responses to all HIPAA Privacy and Security breaches:

- Ensure that the local facility is properly following the AH HIPAA Privacy and Security policies.
- Ensure that any HIPAA Privacy and Security matters are reported on a timely basis to regulatory agencies.
- Confirm that all disciplinary actions are carried out and appear appropriate.
- Ensure that privacy monitoring activities are conducted on a routine basis and review the privacy monitoring activity reports.

3. CMS and State Licensing:

- Ensure that the facility is meeting the Conditions of Participation requirements.
- Ensure that all State licensing surveys are responded to appropriately.
- Ensure that quality related failures that affect coding, billing, reporting, or reimbursement are properly addressed and corrected
- Ensure that appropriate EMTALA policies and procedures are in place and operating effectively.
- Ensure that appropriate monitoring and auditing procedures are operating to identify and respond on a timely basis to any potential or actual violations.

F. Training and Education.

Adventist Health 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 described in the AH System-wide Policy “Code of Conduct and Fraud Awareness Training, Policy # AD-09-003-S:

1. Each local compliance officer, in consultation with the Corporate Compliance Officer, shall designate employees who are to attend compliance training.
2. Compliance education and updates for local compliance officers shall be conducted quarterly 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 electronically by the Corporate Compliance Officer at the Adventist Health corporate office and by each local compliance officer.
5. Each LCO shall introduce all new hires to the AH compliance program and code of conduct through the employee orientation sessions. Presentations may be done live or by other approved means. The LCO will distribute the AH Code of Conduct to all new hires and may use Attachment 1.4 (the “Employee Alert”) to help new employees understand the AH compliance program.
6. 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.
7. 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.

G. Documentation and Record Retention.

Adventist Health 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 Adventist Health 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, including; Transaction Summary, FMV analysis, CEO Attestation, community benefit supporting documents, BCC Approval Memos, etc.)

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

2. Adventist Health Corporate Documents. The Adventist Health Corporate Compliance Officer shall maintain at the Adventist Health 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 Adventist Health 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 Adventist Health Affiliate shall either return to Counsel or dispose of any documents not required to be maintained by the Adventist Health Affiliate under this Program.

H. Employee Reporting of Violations.

1. Employee Reporting and Report Forms. Adventist Health 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.

Adventist Health organizations shall make available to affected employees a Compliance Program Report Form, in the form of Attachment 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 Adventist Health 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. Adventist Health and Adventist Health 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. Terminating Employee LCO Letter. All departing employees will be given a copy of the Terminating Employee LCO Letter. The purpose of this letter is to remind all terminating employees about AH’s Compliance Program and provide them

with a copy of the “Compliance Reporting Form” that is attached in Attachment 1.5 (“CP Entity Terminating Employee Letter”).

5. Exit Interview. All departing employees should be given an opportunity to 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 Adventist Health or an Adventist Health Affiliate. The interview should be conducted by someone other than the departing employee’s immediate supervisor.

I. 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 Adventist Health 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.

J. Auditing the Program.

1. Conducting the Audit. Counsel shall conduct periodic audits of compliance with the Program by Adventist Health and Adventist Health Affiliates. This audit is intended to measure and improve the effectiveness of the Program. The audit shall focus on whether all arrangements involving Adventist Health or an Adventist Health 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 Adventist Health 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 Adventist Health Affiliates. Audits shall be performed with external or internal audit resources under the direction of Counsel.

5. Reporting Non-Compliance. Any non-compliance with the Program by an Adventist Health Affiliate shall be reported to the Corporate Compliance Officer and corrected.
6. 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.

K. 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 Adventist Health organization.
2. Standardized Disciplinary Guidelines. Disciplinary guidelines for intentional violations of the Code of Conduct shall be enforced consistently and uniformly by Adventist Health and Adventist Health Affiliates. Adventist Health and Adventist Health Affiliates shall make clear to their employees that the standards set forth in the Corporate Code of Conduct are important to the Adventist Health 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 Adventist Health 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 Adventist Health 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.

L. 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 Adventist Health 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 Adventist Health organization and the Adventist Health President of the incident and the planned response.

Seven 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/site/corporate_compliance under the Corporate Compliance Department "Compliance Program" folder.

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

Compliance with Laws

Adventist Health policy requires Adventist Health 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 Adventist Health 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, Adventist Health or its Affiliates will seek appropriate guidance .

Reporting of Violations

Adventist Health 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, Adventist Health 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 Adventist Health 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 Adventist Health Corporate Compliance Officer, (877) 336-3566. The local compliance officer, with assistance from the Adventist Health Corporate Compliance Department, will investigate all reports and ensure that proper follow-up actions are taken. Adventist Health 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 Adventist Health 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 Adventist Health 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

Adventist Health and its Affiliates require officers, directors, employees, contractors, and agents to exercise individual loyalty to Adventist Health 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 Adventist Health 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 Adventist Health 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 Adventist Health 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 Adventist Health facility should be based strictly upon medical necessity. Only an appropriately licensed person should determine whether to admit a patient to an Adventist Health facility. Adventist Health 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 Adventist Health facility if such transfer threatens the patient's health or is in violation of law. If applicable, each Adventist Health facility shall adopt patient transfer protocols.

Payment for Referral

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

Accuracy in Billing

Adventist Health 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

Adventist Health 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 Adventist Health or an Affiliate. Personal political activities must not unreasonably interfere with the individual's ability to perform his or her duties for the Adventist Health organization, and must

be consistent with applicable laws, rules, regulations and the policies set forth in this Code of Conduct.

Patient Rights Laws

Adventist Health 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.

ADVENTIST HEALTH

CORPORATE CODE OF CONDUCT

ACKNOWLEDGMENT 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

End of Attachment 1.1, Part 1

Attachment 1.3**ADVENTIST HEALTH CORPORATE COMPLIANCE OFFICERS**

Updated December 10, 2012

CORPORATE COMPLIANCE OFFICER – KEVIN LONGO (916) 781-4719

Facility	Local Compliance Officer & Assistant	Contact Information
Adventist Medical Center-Hanford Hanford, CA	Charles Ricks Jr. Jenelle Mason	Phone: 559.585.5762 Email: RicksC@ah.org
Adventist Medical Center- Portland Portland, OR	Kevin Vernier Elizabeth DeJesus, Dept. Secretary	Phone: 503.261.6010 Email: VernieKD@ah.org
Adventist Medical Center- Reedley Reedley, CA	Charles Ricks Jr. Jenelle Mason	Phone: 559.585.5762 Email: RicksC@ah.org
Adventist Medical Center- Selma Selma, CA	Charles Ricks Jr. Jenelle Mason	Phone: 559.585.5762 Email: RicksC@ah.org
Castle Medical Center Kailua, HI	Travis Clegg Alicia Hatori, Assistant	Phone: 808.263.5142 Email: CleggTL@ah.org
Central Valley General Hospital Hanford, CA	Charles Ricks Jr. Jenelle Mason	Phone: 559.585.5762 Email: RicksC@ah.org
Feather River Hospital Paradise, CA	Patricia Huse No Assistant	Phone: 530.876.7191 Email: HusePS@ah.org
Glendale Adventist Medical Center Glendale, CA	Claudia Kanne No Assistant	Phone: 818.409.8010 Email: KanneCG@ah.org
Howard Memorial Hospital Willits, CA	Brandon Parker Denice Brown	Phone: 707.463.7637 Email: ParkerBC@ah.org
St. Helena Hospital Clear Lake Clearlake, CA	Arlene Taylor Hannah Porter	Phone: 707.963.6260 Email: TaylorAR@ah.org
St. Helena Hospital Napa Valley St. Helena, CA	Arlene Taylor No Assistant	Phone: 707.963.6260 Email: TaylorAR@ah.org
San Joaquin Community Hospital Bakersfield, CA	Sam Itani Irene Enriquez	Phone: 661.869.6180 Email: ItaniSM@ah.org
Simi Valley Hospital Simi Valley, CA	Bill Werner Lisa Calderon	Phone: 805.955.6218 Email: WernerBS@ah.org
Sonora Regional Medical Center Sonora, CA	Rick Dodds Keri Gunter	Phone: 209.536.5012 Email: DoddsRA@ah.org
Tillamook County General Hospital Tillamook, OR	Walt Larson Paula Morris, Asst. x.2260	Phone: 503.815.2263 Email: LarsonWA@ah.org
Ukiah Valley Medical Center Ukiah, CA	Kitty Sandelin Molly Sams	Phone: 707.463.7692 Email: SandelKS@ah.org
Walla Walla General Hospital Walla Walla, WA	Duane Meidinger Cheri Wolcott, Asst.	Phone: 509.527.8088 Email: MeidinDA@ah.org
Western Health Resources Roseville, CA	Bill Wiedemann Charlotte Wright	Phone: 916.780.2483 Email: WiedemBG@ah.org
White Memorial Medical Center Los Angeles, CA	Steven Stubbs Yesenia Gutierrez, Asst. x.5759	Phone: 323.268.5000 x.1887 Email: StubbsSA@ah.org

This list should be revised, as appropriate, from time to time by the corporate compliance officer.

End of Attachment 1.3, Part 1

Attachment 1.4

ADVENTIST HEALTH CORPORATE CODE OF CONDUCT

EMPLOYEE ALERT

Dear Employee:

Adventist Health and its health care facilities and Affiliates 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.

Adventist Health 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 Adventist Health 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 _____. Kevin Longo is the Corporate Compliance Officer responsible for the entire Program. He may be contacted at (916) 781-4719.

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 Adventist Health'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 Adventist Health 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, Adventist Health 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 Adventist Health 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

Attachment 1.5

CP Entity Terminating Employee Letter

[Hospital Letterhead]

[Date]

[Terminating Employee Name]
[Address, City State Zip]

Dear [Terminating Employee Name],

Our patients and community place a high level of trust in [AH ENTITY NAME], and even as you leave our employ, you have a responsibility to report any situation that could jeopardize the care of our patients or violate a law or regulation governing our work. As part of your separation process, we want to give you an opportunity to report any matters that could possibly be improper or perhaps illegal. Reporting any concern now will help assure that the matter is immediately reviewed and appropriate action is taken.

All reports are strictly confidential and may even be anonymous. You have several reporting options available. The enclosed Compliance Report Form may be used for this purpose, or you may speak personally to either your former supervisor or to me. A special toll-free telephone line is also available for reporting Code of Conduct concerns. That number is 1-888-366-3833. It's in operation Monday through Thursday from 8 a.m. to 5 p.m. Pacific Time, and Friday from 8 a.m. to 3:30 p.m.

Our patients' health and safety are of utmost importance, which is why we are giving you this opportunity to share any concern you may have. Reporting a concern, even if it seems small or insignificant, helps assure that the people in our community continue to be well served by a healthcare organization they trust. As you leave our organization, we wish you God's blessing on your future plans.

Sincerely,

[LCO NAME],
Local Compliance Officer

Enclosure

End of Attachment 1.5, Part 1

Attachment 1.6

COMPLIANCE PROGRAM REPORTING FORM

Adventist Health Corporate Compliance Program

Instructions: Please describe your concerns. Attach extra sheets if needed.

Facility: _____

Department(s): _____

Persons Involved: _____

Time Period Concerns/Issues/Incident/Problem Occurred: _____

Describe in as much detail as possible:

This report will be kept confidential in accordance with the Program's procedures and subject to government laws. Please submit it to your supervisor, local compliance officer or the Corporate Compliance Officer at Adventist Health, P. O. Box 619002, Roseville, CA 95661-9002.

Non-retaliation Policy: Adventist Health policy prohibits retaliation against individuals who report activities that may violate the laws, regulations, and facility policies. This includes former as well as current officers, employees, contractors and volunteers. Each report is taken seriously and thoroughly reviewed to make sure proper action is taken.

Anonymity Policy: Adventist Health policy provides for compliance reports to be made anonymously. While giving your name will be helpful if more information is needed, you are not required to include it.

Name and Phone Number

(Do not provide these if you wish to remain anonymous)

Date

End of Attachment 1.6, Part 1

Attachment 1.7

Compliance Program Responsibilities by Department

AH Corporate Compliance Department (CCD):

1. The AH 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.
2. The Corporate Compliance Department is responsible for providing oversight and support to all AH facilities in carrying out their various responsibilities identified in the AH Corporate Compliance Program. Specific department activities include:
 - a. Managing all hotline calls and compliance related discrepancies that come to its attention. The department logs all alleged compliance violations in the compliance case database, triages the issues to identify the anticipated compliance risks, and forwards the case reports to the appropriate LCO to be addressed at the local facility. CCD personnel are expected to monitor the progress of all compliance reported matters and work collaboratively with the LCO to ensure all issues are resolved in a timely and appropriate manner.
 - b. Initiating the periodic (annual) sanction reviews to ensure that each facility compares their employees, physicians, and vendors against the government sanction/exclusion databases.
 - c. Work with each AH facility to ensure that each financial relationship with a referral source, (e.g., physician, etc.), processed according to the AH Contract and Approval Guidelines for Referral Source Arrangements.
 - d. Conduct periodic onsite compliance program reviews.
 - e. Ensure periodic audits are conducted to assess the effectiveness of the charging, coding, and billing processes. These audits include coding, billing, Medicare Secondary Payer (MSP), Important Message (IM), etc)
 - f. Conduct compliance related research on issues of interest or concern to the local AH facilities.
3. Work collaboratively with all AH facility LCOs and departments listed below to maintain and revise the AH compliance program related policies and procedures.

Admitting:

1. Admitting personnel are responsible for registering patients and collecting/verifying patient demographic information. This information must be accurate to ensure that billing information is sent to the appropriate responsible parties (i.e., 3rd party payers, guarantors, and patients)
2. Admitting personnel are responsible for following the AH Compliance program guidelines (Part 10) concerning Patient Identity Protection along with the supporting "Patient Identity Theft Procedures" policy, AD-09-007-S.

3. Admitting personnel are responsible for ensuring that they guard and protect protected health information (PHI) and exercise caution when discussing such information with patients to avoid inadvertent disclosure to the public.
4. Admitting personnel are typically involved in helping to make sure the Medicare Important Message (IM) is reviewed with the patient and signed by the patient. The IM is a tool for communicating an admitted patient's right to contest their discharge if they do not believe the discharge is appropriate.
5. Admitting personnel are considered "Affected Employees" for compliance fraud awareness education and must complete annual compliance education.

Case Management/Utilization Review:

1. Case management staff are responsible for monitoring patients' progress and working with physicians to help ensure appropriate levels and types of care are provided to achieve quality outcomes.
2. In some facilities CM/UR staff work hand-in-hand with Health Information Management to help ensure that medical chart document is adequate and complete to support the medical necessity requirements of both government and commercial 3rd party payers.
3. CM and UR staff are typically in AH Facilities responsible for working with admitting personnel to ensure that a copy of the 2nd IM is provided to Medicare patients within 2 days of discharge. (See AH Policy # PFS-192)

Compliance Education/ Staff Education:

1. LCOs are responsible for working with designated hospital employees to ensure that all new hires complete fraud awareness training within 90 days of their hire date.
2. Additionally, "affected" employees, which are defined in AH Code of Conduct and Fraud Awareness Training policy, AH-09-003-S, are expected to complete refresher training on a periodic basis as designated in the AH policy.
3. Individuals responsible for compliance education at the local level will work with the LCO to maintain the routine reporting of "New Hires" and "Affected Employees" compliance education completion statistics.

EMTALA - Emergency Department (ED):

1. Emergency personnel are responsible for ensuring that the Emergency Medical Treatment and Active Labor Act (EMTALA) is followed during the treatment of patients that present to the hospital with an emergency medical condition. EMTALA requires that facilities stabilize patients with an emergency condition without regard to their ability to pay. Facilities are subject to sizable fines and penalties should they fail to conform to the requirements of EMTALA.
2. Emergency department admitting personnel are responsible for knowing how to collect patient demographic and financial information so as to avoid violating EMTALA requirements.

3. Emergency department personnel are also responsible for ensuring that proper signage, "It's the Law," is posted prominently in the Emergency department.
4. The Emergency department is also responsible for maintaining "Safe Surrender" policies and packets. These packets contain the policy and all necessary documentation for use when and if a mother chooses to give up her baby. Emergency department nursing and admitting personnel must be aware of these procedures.

EMTALA - Maternity/OB/Labor and Delivery (L&D):

1. The Maternity/OB/Labor and Delivery department, like the Emergency Department, is responsible for complying with the EMTALA regulations. The regulations that apply to the Emergency department also apply in the Maternity/OB/Labor & Delivery units.

Financial Accounting:

- 1) Accounting staff will be responsible for comparing on an annual basis all vendors in the vendor master to the government Sanction/exclusion databases (i.e., Office of Inspector General OIG, DHS/Medi-Cal, & Government Services Administration System for Award Management SAM). This comparison is to ensure that the facility is not making payments to any excluded individuals or entities.
- 2) Accounting staff will be responsible for comparing all new vendors that are added to the accounts payable vendor master file to the government sanction/exclusion databases. This comparison is to ensure that the facility does not make payments to any excluded individuals or entities.
- 3) Accounting staff are generally responsible for working with AH Corporate Office Budget/Reimbursement department and/or outside consultants to prepare the annual cost reports.

Health Information Management (HIM):

1. HIM is responsible for properly maintaining the patient medical records.
2. HIM coding personnel are responsible for reviewing the medical record documentation and properly assigning diagnosis (ICD-9 or ICD-10) and CPT-4 codes. These codes communicate to government and commercial payers the patients' conditions and treatments/procedures received.
3. Accurate coding is vital because hospital reimbursement is determined by the codes assigned by HIM coders. Inappropriate and false coding exposes the facility to the False Claims Act fines and penalties.

Facility Privacy Official (FPO):

1. Hospital administration is responsible for ensuring that a qualified individual is designated as the Facility Privacy Official. This position is frequently assigned to the HIM director.
2. The FPO is responsible for ensuring that AH HIPAA Privacy policies and procedures are maintained and followed.
3. The FPO is also responsible for ensuring that HIPAA privacy breaches are properly investigated and resolved.
4. The FPO is also responsible for ensuring that privacy breaches are properly reported to government authorities according to the various laws.

Facility IT Security Official (FSO):

1. Hospital administration is responsible for designating a qualified individual as the Facility IT Security Official. This position is frequently an IT manager but is often assigned to the FPO or Chief Financial Officer.
2. The FSO is responsible for ensuring that HIPAA Security policies and procedures are maintained and followed.
3. The FSO is responsible for investigating IT Security breaches and working with the FPO to assess the violation to take appropriate corrective action.

Home Health Agency (HHA):

1. Many AH facilities have Home Health Agencies that operate as departments of the hospital. In some cases, the agencies are actually operated by WHR, a subsidiary of AH.
2. The Home Health Agency management are responsible for following the guidelines defined in Part 3 of the AH Compliance Program.
3. The Home Health Compliance Program identifies the common compliance risk areas that HHAs must be guarded against. These risks include:
 - a. Billing services only for “home bound” patients,
 - b. Assigning proper codes to the claims, and
 - c. Submitting bills only for medically necessary services, to name a few.

Hospital Based Clinics:

1. The hospital based clinic management is responsible for ensuring that the clinics adopt and follow the AH Compliance Program Part 7 – Hospital Based Clinics.
2. The general risk areas for clinics that are addressed in Part 7 of the compliance program are:
 - a. AH facilities do not pay for referrals
 - b. Compensation arrangements with physicians will conform to AHs Referral Source Guidelines, which are designed to meet Antikickback and Stark Self-Referral regulations.

- c. Physicians are responsible for patient care and their patient encounters must be coded according to industry standards.
 - d. Services provided to patients will be medically necessary and appropriate for their condition.
3. Hospital based clinics will establish policies and procedures to:
 - a. Ensure billed claims will be honest, accurate and complete.
 - b. Submitted claims will be for services that are medically necessary.
 - c. False statements involving billing and coding will not be tolerated.
 - d. Assigned CPT-4 and ICD-9 codes will accurately reflect the services provided.

Human Resources (HR):

1. In addition to its typical function of making sure the AH facility management and employees comply with the multitude of labor laws, the Human Resource department is also responsible for specific compliance program policies and procedures. One of the significant functions is taking responsibility for hiring personnel that are not excluded or sanctioned by the government. HR personnel must compare each new hire to the government sanction/exclusion databases (OIG, Medi-Cal, & SAM).
2. HR is responsible for the staff orientation program. As part of orientation, all new hires must be familiarized with the AH Code of Conduct (COC). This is done through a face-to-face meeting with the LCO, viewing the COC video, It's Everybody's Responsibility," and reviewing the COC brochure.
3. HR is also responsible for maintaining documentation in the personnel files to substantiate that the new employees completed orientation, viewed the COC presentation, and signed HIPAA Privacy, Security, and confidentiality statements.
4. HR is also responsible for ensuring that the AH Compliance Reporting form is available on Intranet.
5. HR personnel are also responsible for working closely with the LCOs, FPOs and FSOs to ensure that disciplinary actions are appropriate with respect to compliance and HIPAA privacy/security violations.

Information Technology (IT):

1. Information Technology is responsible for the supporting technology that modern healthcare is built on. This includes the vast array of computer software and hardware systems that are integral to caring for and serving our patients.
2. These systems are vital, not only for treating and diagnosing patients, but capturing the charges and properly coding the services so that our AH facilities can be properly paid for our services.
3. Critical to billing medically necessary services are electronic edits, audits, testing, and security measures that ensure facility medical records contain documentation that accurately supports and reflects the services provided.

4. IT is also responsible for establishing and maintaining policies and procedures to safeguard all electronic data to prevent loss and inappropriate use.

Laboratory:

1. The laboratory management are responsible for ensuring that the AH facility laboratory operates in accordance with Part 4 of the AH Compliance Program. This program identifies the primary laboratory compliance risk areas.
2. The laboratory must ensure that laboratory tests performed are ordered by a physician and that the tests meet specific medical necessity policies. This is accomplished by:
 - a. Laboratory receptionists comparing ordered tests to an electronic medical necessity “checker” to ensure that tests ordered are billable for the diagnosis provided by the physician.
 - b. Laboratory personnel must obtain an “Advanced Beneficiary Notices” (ABN) from Medicare patients when tests fail the medical necessity edits. ABNs provide the necessary notification to the patient that enables a laboratory to bill the patient for tests that fail the medical necessity edits.
 - c. Use of the Medical Necessity Checker is optional, provided management has established policies and procedures to ensure that Medicare beneficiaries are not billed for claims Medicare denied due to a failure to meet medical necessity requirements.
3. Laboratories must also include certain features on their laboratory requisition forms to help ensure that physicians only order tests that are medically necessary. These include:
 - a. Specific statements that remind the physician to order medically necessary tests.
 - b. Space to accommodate ICD-9 diagnosis codes, which provide information to support the medical necessity of the tests ordered.
 - c. The listed tests should include CPT-4 codes so that physicians know exactly what they are ordering.
 - d. Specific chemistry panel tests must be so identified that the ordering physician can tell what tests are included in the panel.
4. Laboratory management is also responsible for sending out annual notices to their physician clients notifying them concerning the various chemistry panels that are available for their use. These letters include detailed lists of the individual component tests and their associated Medicare reimbursement rates.
5. Laboratory management must also conduct periodic reviews of “standing orders” to ensure they are updated at least every 12 months/1 year.
6. Laboratory staff are expected to complete the annual review of the AH Laboratory Compliance Program using the HealthStream Learning Center training modules.

Medical Staff:

1. The Medical Staff department is responsible for credentialing and re-credentialing physicians on the medical staff. The elements of the AH compliance program this department is responsible for are:
 - a. Compare the physicians on the medical staff against the sanction/exclusion databases (OIG, Medi-Cal, & SAM) each year.
 - b. Compare new physician applicants against the government sanction/exclusion databases before accepting them on the medical staff.
 - c. Obtain signed confidentiality statements from the physicians.
 - d. Obtain signed HIPAA Privacy and Security statements from the physicians.

Out Patient Rehabilitation (OPR):

1. AH Facilities' OP Rehab management are responsible for ensuring that the services performed are ordered by a physician, are medically necessary for the patient's condition, and that patient record documentation is complete and accurate.
2. In particular, OPR personnel are responsible for ensuring that treatment times include total therapy time and individual modality start and stop times.
3. They are also responsible for ensuring that the procedures are properly coded for billing purposes.

Patient Financial Services (PFS):

1. The PFS management is responsible for ensuring that their facilities' billing processes conform to the AH Compliance Program Part 6 – Patient Financial Services.
2. The department's responsibilities include ensuring that appropriate policies and procedures are in place to protect against the common risk areas identified in the PFS compliance program. The actions required to avoid those risk areas include:
 - a. All submitted claims will reflect services that are documented in the patient medical records.
 - b. Billed items will represent services actually rendered.
 - c. Maintain effective policies and procedures to prevent the submission of duplicate bills.
 - d. Services that are required to be bundled are submitted appropriately.
 - e. The charge description master will be maintained so that charge descriptions will accurately reflect the associated CPT-4 and revenue codes.
 - f. PFS will work with the AH Information Systems team and outside contractors to maintain the various electronic claim editors.
 - g. Policies and procedures will be followed to ensure that services subject to the 3-day window regulations will be properly billed.

- h. PFS personnel will work collaboratively with HIM and IS personnel to ensure that claims are submitted with discharge codes that accurately reflect the actual discharge status of patients.
- i. PFS personnel will maintain procedures to ensure that credit balances are appropriately identified and promptly refunded to the 3rd party payers.
- j. PFS personnel are also responsible for ensuring that billing and collection personnel follow Medicare guidelines regarding Medicare Bad Debts.
- k. PFS personnel are responsible for ensuring that the policies concerning changes to diagnoses codes are properly followed.
- l. PFS personnel must also follow appropriate policies and procedures to address claim denials, underpayments, improperly paid claims, and claims not paid according to contract.
- m. PFS managers are responsible to ensure that billing staff incentive compensation arrangements are properly structured.
- n. PFS personnel are also responsible for working collaboratively with HIM and service line departments to ensure that CPT-4 modifiers are properly assigned.
- o. PFS personnel are responsible for establishing and following proper procedures regarding the waiver of co-payments and deductibles.
- p. PFS departments must also follow proper record retention policies with respect to the billing documentation.
- q. PFS personnel are expected to work collaboratively with HIM and other departments to ensure that the various claim and coding audits are completed as required.
- r. PFS personnel are identified as “affected” employees and must complete routine compliance education in accordance with AH Compliance Education policies.

Physician Contract Specialists:

1. Hospital administration will be responsible for assigning qualified individuals in their local facility to manage all physician contracts in accordance with the AH Compliance Program Referral Source Guidelines.
2. The designated individuals will work with the CCO and Counsel to ensure each physician contract is prepared, reviewed, and approved in accordance with AH guidelines.

Quality and Accreditation:

1. Accreditation personnel are responsible for facilitating processes that ensure AH facilities maintain accreditation. The accreditation process demonstrates that a facility meets CMS conditions of participation. Meeting CMS conditions of participation requirements is the key that allows a healthcare facility to bill government programs for services rendered to government health care program beneficiaries.
2. The Quality department works collaboratively with hospital administration, patient care teams, and designated medical officers to help ensure that patients receive a high

level of quality care. This is increasingly important from a compliance perspective because the Center for Medicare and Medicaid Services (CMS) has made certain portions of hospital reimbursement contingent on reporting and eventually achieving specific levels of quality of care.

3. Health care provider legal boards are expected to take responsibility for ensuring that their facilities' maintain appropriate quality of care levels. The AH Legal Board has incorporated strategic quality initiatives in AH's Strategic Plan and looks to hospital Administration, Quality, and Medical Staff achieve AH's strategic plan goals.
4. Increasingly, the government views maintenance of quality care a condition of participation in the Medicare and Medicaid programs.

Risk Management (RM):

1. Risk Management departments are responsible for ensuring that adverse medical events are properly reported to the appropriate State agencies.
2. RM personnel are also responsible for logging, tracking, and coordinating responses to patient complaints. There are specific AH System-wide policies and procedures that govern the reporting of such information. Common events include: patient care events, slips and falls, and security issues.
3. This department works collaboratively with patient care units, HIM, and PFS to ensure that patient accounts are properly reviewed and adjusted in accordance with AH System-wide "Disputed Services Discounts" policy, PFS-143.
4. The RM department is typically responsible for ensuring that the "Safe Medical Device Act" (SMDA) is complied with and that medical device issues are properly reported.

Rural Health Clinics (RHC):

1. RHCs management is responsible for ensuring that their facilities' operations conform to the AH Compliance Program Part 9 – Rural Health Clinics.
2. The general risk areas for clinics that are addressed in Part 9 of the compliance program are:
 - a. AH facilities do not pay for referrals
 - b. Compensation arrangements with physicians will conform to AH's Referral Source Guidelines, which are designed to meet Antikickback and Stark Self-Referral regulations.
 - c. Physicians are responsible for patient care and their patient encounters must be coded according to industry standards.
 - d. Services provided to patients will be medically necessary and appropriate for their condition.
3. Hospital based clinics will establish policies and procedures to:
 - a. Ensure billed claims will be honest, accurate and complete.
 - b. Submitted claims will be for services that are medically necessary.

- c. False statements involving billing and coding will not be tolerated.
- d. Assigned CPT-4 and ICD-9 codes will accurately reflect the services provided.

End of Attachment 1.7, Part 1

Adopted: September 22, 1997

**ADVENTIST HEALTH
Corporate Compliance Program**

PART 2: Referral Source Contracting Approval Guidelines

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 addresses “Contract Guidelines” for developing certain contracts with referral sources, and sets forth “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 in this document.

B. When to Use the Contract Guidelines 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) that:¹
 - 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. Arrangements with a physician, person or entity that **receives** patients or business **from** an AH Affiliate.
3. Any contract or arrangement between an AH Affiliate and any referral source who arranges any business for the AH Affiliates.
4. 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).
5. 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. Any contract or arrangement between one AH Affiliate and another AH Affiliate if:
 - a. there are no patient referrals between them, or
 - 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).

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

2. Agreements between individual physicians and medical groups that subcontract or are affiliated with an AH Affiliate.
3. Contracts between AH home health agencies and an AH Affiliate, provided that the guidelines in this Program for home health agencies are followed.
4. Payer contracts between an AH Affiliate and a payer. Note, however, that legal risks may arise from these arrangements, and legal counsel should be consulted.
5. 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 Contract Guidelines for provider/physician transactions. The following model agreements have also been developed for use with the Contract Guidelines:

	Model Agreements
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.	Generic Letter Agreement
9.	Generic Transaction Summary
10.	Loan and Security Agreement
11.	Management Services Agreement
12.	Medical Directorship Agreement
13.	Medical Office Lease Agreement (favors Landlord)
14.	Medical Office Lease Agreement (favors Tenant)
15.	Medical Office Lease Guaranty
16.	Medical Practice Asset Purchase Agreement

17.	Physician Employment Agreement
18.	Practitioner Recruitment Agreement (Solo)
19.	Practitioner Recruitment Agreement (Group)
20.	Professional Services Agreement (Solo)
21.	Professional Services Agreement (Group)
22.	Teaching Services Agreement (Solo)
23.	Teaching Services Agreement (Group)

The Contract Guidelines and model agreements are maintained and accessible within the Latham & Watkins ComplianceNet program on the Internet at <https://ah.compliancenet.lw.com>. AH Affiliates shall strive to materially comply with the Contract Guidelines and use the model agreements, except as otherwise allowed by the person(s) responsible for final approval.

The AH Affiliate contract specialist should always begin with the model agreements.

E. Approval Guidelines

Any proposed arrangement subject to this Part 2 must comply with the content of the Approval Guidelines in Physician Arrangements Review Process Policy AD-09-008-S prior to an AH Affiliate executing an agreement or making any payment under the arrangement.

DRAFT Pending Further Review & Legal Approval

Entity(s):

Network:

X Systemwide Corporate Policy
Corporate Policy No.

X Standard Policy

Model Policy:

Entity(s) Policy No. AD-09-008-S

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Department: Compliance

Category/Section: Regulatory Compliance
Manual(s):

POLICY: PHYSICIAN ARRANGEMENTS REVIEW PROCESS

POLICY SUMMARY/INTENT: Adventist Health is committed to ensuring that all arrangements with Physicians (i) are in compliance with all regulatory and legal requirements; (ii) further our mission and enhance our ability to share God's love through the provision of physical, mental and spiritual healing, and (iii) respect our values, including our responsibility to be proper stewards of the financial resources available to us.

It is the intent of AH to provide a robust and thorough review process of its Physician Arrangements to ensure each one aligns with our commitment. This policy for a Physician Arrangement Review Process (this "**Policy**") details guidelines for Physician compensation, benchmark and compensation standards, utilization of third party valuation consultants, and the transaction review process. It was designed to enhance the effectiveness and efficiency of the Physician Arrangements review process at AH, narrow the Physician Arrangements variations that may exist within the system, and increase the use of "best practice" Physician Arrangement components.

DEFINITIONS AND EXHIBITS SCHEDULE:

1. **AH:** Adventist Health System/West.
2. **AH Legal:** The AH law department. AH Legal is in the process of expanding its staff so that more matters can be handled within the department. During the transition in house, AH Legal will continue to delegate transactions to Latham & Watkins (or other law firms). Approval of delegated transactions by Latham & Watkins will constitute approval of AH Legal for purposes of this Policy.
3. **AHPS:** The Adventist Health Physician Services team, which oversees clinic operations within AH.
4. **Acquired Physician:** A Physician who currently provides professional services in an Affiliate's or Facility's market, but who does not have a Clinic Arrangement (as described in Section II.A below) with that Affiliate or Facility.
5. **Affiliate:** An entity that AH directly or indirectly manages or controls, with control including entities as to which AH (a) owns all of the outstanding stock, membership, or other ownership interests, or (b) has the ability to appoint all of the members of the entity's governing body.
6. **BCC:** The Board Compliance Committee of AH and of each Affiliate.
7. **CLM:** The Contract Lifecycle Management system designated by AH Legal, which is currently the Latham & Watkins ComplianceNet system.
8. **Established Physician:** A Physician who is renewing a Clinic Arrangement with AH or an Affiliate.
9. **Facility:** AH, or a hospital, critical access hospital, medical foundation, or medical group, which is owned, operated, managed, leased, or controlled, directly or indirectly, by AH or an Affiliate.
10. **Fair Market Value:** Value in a bona fide, arm's-length transaction negotiated between well-informed parties, where the price or compensation has not been determined in any manner

- that takes into account the volume or value of anticipated or actual referrals between the parties.
11. **New Physician:** A Physician who does not currently provide professional services in the market where AH or an Affiliate will locate the Physician's primary site of service.
 12. **PCAT:** AH's Physician Compensation Assessment Tool, which uses a blend of Medical Group Management Association ("MGMA"), Sullivan & Cotter ("SCA") and America Medical Group Association data for benchmarking Physician compensation and productivity for professional services.
 13. **Physician:** A doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor.
 14. **Physician Arrangement:** A direct or indirect compensation arrangement with a Physician, Physician organization (e.g., a medical group), or a Physician-owned entity. A Physician Arrangement also includes a compensation arrangement with any entity for the provision of Physician services.
 15. **Physician Arrangements Review Team ("PART"):** A group of individuals designated by AH from time-to-time, including representatives from Regional CFO, AHPS CFO, AH Legal, AH Compliance and AH Executive Cabinet, which advises Affiliates' BCC and boards of directors as to Physician Arrangements.
 16. **Physician Compensation – Clinical Compensation ("Clinical Compensation"):** Compensation for direct patient care activities. (This does not include compensation for administrative services or call coverage.)
 17. **Physician Compensation – Total Cash Compensation ("TCC"):** All compensation paid to a Physician by all Affiliates, whether through employment, professional service, directorships, call payments, lump sum payments, quality bonus, other service payments, etc.
 18. **Physician Contract Template:** A model physician contract that AH Legal has titled "template" and which is maintained by AH Legal.

Exhibits Schedule

- A. Physician Compensation Assessment Tool
- B. PCAT - Call Pay Calculator
- C. Facility Business Plan Pro Forma
- D. Physician Practice Pro Forma
- E. Physician Arrangement Approval Flow Matrix
- F. Physician Arrangements Review Package

AFFECTED DEPARTMENT(S)/SERVICE(S):

1. All AH Departments

2. All Hospital Departments
-

POLICY: COMPLIANCE – KEY ELEMENTS**I. Physician Arrangements Philosophy and Principles**

AH's Mission, Vision and Values promote a consistent and fair approach to Physician Arrangements. Each Facility must ensure that its local policies and processes adhere to the Physician Arrangements Philosophy and Principles defined below:

A. Physician Arrangements Philosophy (“Philosophy”)

Physician Arrangements should promote alignment with Physicians and reflect the AH mission and core values. AH supports Physician compensation principles that recognize productivity (where appropriate) and financial responsibility, while also promoting quality of care, clinical coordination, and improved patient outcomes. This Philosophy provides a framework for developing consistent, equitable and Fair Market Value Physician compensation structures that respond to local market conditions, comply with regulatory requirements, recognize exemplary performance, and create incentives for quality, efficiencies and productivity.

B. Physician Arrangements Principles (“Principles”)

AH encourages a standard approach to Physician Arrangements within each Facility. Facilities should use the following principles to guide development of Physician Arrangements:

1. Physician Arrangements should be fair. Physician compensation must never consider or take into account the volume or value of referrals to an Affiliate.
2. Physician Arrangements must comply with all federal and state legal requirements, including the Stark Law, the Anti-Kickback Statute, the Civil Monetary Penalties Law, and relevant IRS rules.
3. Physician Arrangements should be market driven, and they must be commercially reasonable and supported by Fair Market Value documentation.
4. Physician Arrangements should be consistent with the standards set forth in this Policy. If compensation for a proposed Physician Arrangement falls outside of such standards, as determined by the Physician Compensation Assessment Tool, the Facility must submit to PART a reasoned analysis supporting the requested exception. BCC review and approval may also be required, as outlined in the Physician Arrangements Review Process section of this Policy and as otherwise determined by the PART.
5. Physician Arrangements should foster a partnership culture that recognizes the strategic value of synergies and drives mutual success for both the Physician and the Facility.

II. Physician Arrangement Types and Related Standards for Compensation

Each Facility must establish compensation models that honor the standards set forth in this Policy. In any particular situation where compensation for a proposed Physician Arrangement might fall outside of these standards, the Facility must provide a reasoned analysis, as described in the Physician Arrangements Review Process section of this Policy. Facilities should engage in early consultation with members of PART (including AH Legal) regarding the applicability of these standards to any particular situation, including situations involving models or methodologies that

are unique to a Facility (or its market). PART will be able to identify resources available to the Facility to help address unique situations.

A. Clinic Arrangements (e.g., PSAs for HBOCs, RHCs or AHPN clinics, PEAs)

1. Compensation for Physicians' clinical services may consist of various models, including:
 - a. Base Guarantee
 - b. Production
 - a. Work RVU's
 - b. Payment per visit (Standard for RHC)
 - c. Combination of 1 & 2
 - d. Payment of Base Rate plus Bonus Incentive
 - e. Other models as approved by AH Legal and PART

Standards:

To facilitate the assessment of the compensation associated with a proposed Clinic Arrangement, AH has created the PCAT (see **Exhibit A**). The PCAT report generated by a Facility should be based upon the National data. AH understands that the utilization of survey data from multiple and/or different specialties may be necessary in certain situations. Such situations might involve a Physician with multiple subspecialties or emerging specialties for which survey data is not available. A Facility should cause a PCAT report to be run early in the contracting process so that the Facility can have the information available to it during its negotiations with the Physician.

2. Regardless of the compensation model utilized, AH recommends including value-based at-risk components in order to align Physician practices with the Facility's strategic and clinical objectives. Some common value-based incentives include the following:

Quality:

AH is committed to the provision of quality care and patient safety across the treatment continuum. AH recommends inclusion of quality incentives in Physician compensation in order to meet this commitment. Examples of quality incentives include compensation for recognition by the National Committee for Quality Assurance or performance in relation to Physician Quality Reporting System measures. To ensure the objectivity of quality incentives, the establishment of baseline data against which quality performance can be measured is critical.

Patient satisfaction:

Survey results may also be used as a value-based incentive along with individual Physician Hospital Consumer Assessment of Healthcare Providers and Systems survey scores. Incentives must not be associated with hospital length of stay (or give the appearance that they are associated with reducing services), as they impose risk of violating the Civil Monetary Penalties Law.

Access to Care:

Access to health care, for all segments of society, is a central theme of AH's mission. Physicians play a critical role in efforts to reach the most vulnerable populations. Clinic compensation models may include a

component that provides incentives to care for uninsured, underinsured and underserved patients.

Standards:

Compensation models must be designed such that the addition of value-based incentive components do not cause the TCC to exceed Fair Market Value. Therefore, AH recommends that value based incentive components not exceed 20% of Clinical Compensation. Value based incentive targets must be outlined in advance of the measurement time period, and must be reviewed on a frequent basis to ensure they represent realistic stretch targets.

3. To facilitate required mid-level supervision and support Physician-directed care plans, Facilities may consider compensating Physicians for mid-level supervision.

Standards:

In general, supervision compensation should be based on the number of mid-level charts reviewed (in accordance with the Facility's policies) at a dollar amount that is Fair Market Value and that does not cause TCC to exceed Fair Market Value.

B. Administrative Services Arrangements

Administrative Services Arrangements (such as medical directorships) are used in a variety of situations associated with Facility operations. Facilities must identify:

1. Why the administrative services are required by the Facility,
2. The expected minimum and maximum hours of services that are needed by the Facility each month, and
3. Why the number of hours are reasonable (which the Facility may support with survey data).

In most situations, administrative services are compensated on an hourly rate basis. Physicians contracting with a Facility to provide compensated administrative services must maintain time records and regularly submit them to that Facility. An appropriate representative of the Facility must verify and approve the accuracy of the time records.

Standards:

In general, administrative services should be paid at the lesser of the following rates or at rates that would not cause TCC to exceed Fair Market Value:

Primary Care	\$150/hour
Medicine Specialties	\$175/hour
Surgical Specialties	\$225/hour

Facilities proposing Administrative Services Arrangements with rates above these standards must submit those arrangements for PART review.

C. Call Coverage Arrangements

Facilities often need to pay Physicians for hospital call coverage. When considering potential Call Coverage Arrangements, Facilities should consider multiple factors, including specialty, payor mix, and call frequency.

Standards:

To facilitate the assessment of a proposed call coverage stipend, AH has created the "PCAT - Call Pay Calculator" (see **Exhibit B**). The Call Pay Calculator is based on what industry leaders such as MGMA, SCA, and others consider in their Fair Market Value

analysis of call pay. All proposed Physician Arrangements that include a call rate above the parameters established in the Call Pay Calculator require PART approval.

D. Other Physician Arrangements.

Other types of Physician Arrangements may be subject to standards for compensation as set forth in other AH policies, and may include Hospital Based Physician Arrangements, Physician Recruitment Arrangements (see AH Physician Recruitment Policy), Teaching Services Arrangements, Equipment and Space Lease Arrangements, Asset Purchase Arrangements, Medical Staff Leadership Stipend Arrangements, Education, Retreats, Conference and Seminar Arrangements (see Physician Incidental Payment Policy for Adventist Health, AD-09-016-S), Residency Arrangements, Locum Tenens Arrangements, Loans, Lines of Credit or Guarantee Arrangements, and other miscellaneous physician compensation arrangements. The AH Legal or AH Compliance Departments can assist Facilities with identifying other specific standards that may apply to these other types of Physician Arrangements.

III. Overarching Physician Arrangements Considerations and Standards

A. Fair Market Value

All Physician Arrangements must be within Fair Market Value. TCC paid to a Physician by all Facilities must not exceed Fair Market Value. It is the responsibility of the Facility to assemble and document the basis for any conclusion that the arrangement is within Fair Market Value. The Facility will be required to utilize the PCAT review forms as part of the Fair Market Value documentation.

Standards:

All third-party Fair Market Value compensation opinions must be engaged and managed through PART. This will ensure reports are sufficient and appropriately utilized. AH Legal will coordinate the process for obtaining all third-party reviews under the guidance of PART.

B. Commercially Reasonable

All Physician Arrangements must be commercially reasonable. The Facility must document that the overall transaction makes commercial sense and accomplishes the intended business purposes in a logical manner, without any consideration for potential referrals from the Physician. Facilities must document that there is a genuine need for the arrangement (and the number of hours, if applicable), whether there are any lower cost alternatives available, and whether the arrangement could be accomplished without a Physician's involvement. The Facility will be required to utilize the PCAT review forms as part of the commercial reasonableness documentation.

C. Billing/Coding Reviews

Each Facility must conduct regular billing and coding reviews of Physicians for whom AH or a Facility bills and collects according to AH policy.

D. New Physician Pro Forma

For each new Clinic Arrangement and Physician Recruitment Agreement, the Facility must prepare and submit a Physician Practice Pro Forma (see **Exhibit D**) and a Facility Business Plan Pro Forma (see **Exhibit C**). The Facility Business Plan Pro Forma should complement the Facility's strategy, be based on sound business principles and parameters, and reflect appropriate due diligence, but it must never be used to determine or rationalize the amount of Physician compensation or recruitment incentives.

E. Annual Compensation & Subsidy Reviews

At least once in each calendar year, AHPS will review the year-to-date compensation factors of all Clinic Arrangements.

Standards:

The annual review will include factors similar to the Full Review factors included below in Article IV, Section A1.a. AHPS will work with each Facility to determine any necessary documentation and/or suggested modifications for each Physician's Clinic Arrangement, based on the outcome of the annual review.

F. Finance Reviews

The purpose of any Finance Review of a Physician Arrangement is to ensure discharge of management and the Affiliate's board of director's fiduciary duties with respect to stewardship of charitable assets.

As part of the Finance Review, the Facility CFO, the Regional CFO and, as applicable, AH Finance, will review financial information to ensure the proposed Physician Arrangement is at Fair Market Value, is commercially reasonable, and is consistent with budget and the Facility Business Plan Pro Forma. Finance Review should be conducted for Physician Arrangements in accordance with established approval levels.

Finance Reviews begin with the Facility's budget. Finance Reviews also include review of the Facility Business Plan Pro Forma associated with the proposed Physician Arrangement, which pro forma includes existing and projected results of operations inclusive of the proposed Physician Arrangement, a review of whether there are sufficient Facility resources to implement the proposed Physician Arrangement, and a demand/volume to justify the proposed Physician Arrangement.

A Facility Business Plan Pro Forma associated with a proposed Acquired Physician transaction must never take into account referrals that might be redirected by the Acquired Physician from other facilities to the AH Facility.

A Facility must never use a Facility Business Plan Pro Forma to justify, support or rationalize the amount of compensation associated with a Physician Arrangement.

In order to ensure that no components associated with the Finance Review are used to determine the compensation to be paid under a Physician Arrangement, AHPS staff will negotiate all Clinic Arrangements and will not have access to, or information from, the Facility Business Plan Pro Forma.

G. Quarterly Reports to BCC

AH Compliance will make quarterly reports to BCC regarding the Physician Arrangements that have been approved and executed since the previous quarterly report.

IV. Physician Arrangements Review Process

AH intends that the Physician Arrangements Review Process assess the consistency of Physician Arrangements with AH's standards and to apply the appropriate level of review to arrangements based upon established criteria. AH also intends the review process to allow Facilities to quickly execute Physician Arrangements that are within certain standards set forth in this document. (See **Exhibit E** - Physician Arrangements Approval Flow Matrix.)

Facilities must complete a Physician Arrangements Review Package (the "**Package**") for all Physician Arrangements (see **Exhibit F**). Packages provide a source of pertinent information for

review of the arrangement. The Package will become a permanent part of the Facility's Physician contract file.

A. Initiation of Physician Arrangements Review Process

1. The Physician Arrangements Approval Flow Matrix summarizes the documents and approvals required for each Physician Arrangement. The Matrix also identifies the types of Physician Arrangements for which a PCAT, third-party Fair Market Value opinion, a Facility Business Plan Pro Forma and a Physician Practice Pro Forma are required.
2. Each region is responsible for establishing its process for obtaining Regional CFO approval of each Physician Arrangement. Regional CFO approval must be documented and included within each Package.
3. Facilities are encouraged to consult with AH Legal early in the Physician Arrangement process with regard to non-routine arrangements. Early consultation with AH Legal is not a substitute for the requirement that a Facility submit a complete Package before AH Legal commences any formal review of a matter.
4. For each Physician Arrangement, the Facility will create a new matter in the CLM system and will upload into the CLM a complete Package pertaining to the Physician Arrangement. In addition, the submitting Facility must complete all required information fields indicated in the CLM system.
5. After the Facility (i) has obtained Regional CFO approval of the Physician Arrangement, (ii) has created a matter in the CLM system, (iii) has uploaded the complete Package, and (iv) is ready for legal review of the Physician Arrangement, the Facility will send an e-mail to AH Legal notifying it of the Facility's request for legal review. The e-mail to AH Legal must identify the CLM matter number (i.e., the Transaction Number). AH Legal will promptly review the Package, and once AH Legal verifies it is complete, AH Legal will assign it to an attorney for review.
6. The following will cause an automatic delay in AH Legal processing a new request:
 - a. Failure to submit a complete Package. AH Legal will not begin to review any matter where either the Package or the mandatory fields in the CLM system are not complete.
 - b. Pressing the "Post to Legal" tab in ComplianceNet. Only AH Legal may "post" a matter, which it will do only after it has verified the Package is complete.
 - c. Latham & Watkins will not work on any matter without AH Legal approval, which approval requires a complete Package and completion of all CLM mandatory fields.
7. The assigned attorney will notify the Facility and AH Compliance after the attorney has completed his/her review so that AH Compliance can update its database (for Express Reviews) and process Physician Arrangements subject to Limited and Full Review for PART and/or BCC review. After a Physician Arrangement has received the necessary approvals (Regional CFO, Legal,

PART, and/or BCC, as applicable), the Facility can cause the approved contracts associated with the Physician Arrangement to be executed.

8. The Facility must promptly upload fully executed Physician Arrangements contracts into the CLM system within five days following execution.

B. Scope of Physician Arrangements Reviews

AH has the following levels of reviews for Physician Arrangements:

- Express Review (Designated Regional Executive)
- Limited Review (PART)
- Full Review (PART --> BCC)

1. Full Reviews

Full Reviews involve review of the arrangement by AH Legal, PART and BCC prior to execution and before the Physician provides any services. PART will provide its findings and recommendations to BCC, which has the authority to grant or withhold approval of the Physician Arrangement.

Required materials for Full Reviews are included in the Package, except that PART and BCC will not receive or review Facility Business Plan Pro Formas.

a. Types of Physician Arrangements Requiring a Full Review

Physician Arrangements that require a Full Review are arrangements with one or more of the following features:

New Physician Clinic Arrangement

1. Physician Arrangements in which the initial year's TCC is at or above the 75th percentile of the relevant benchmark.
2. Physician Arrangements in which the compensation model utilizes a compensation per wRVU conversion factor that exceeds the 60th percentile of compensation per wRVU of the relevant benchmark.
3. Physician Arrangements wherein the Physician meets the definition of a "disqualified person" under the I.R.S. regulations (see PCAT review forms).
4. The Physician Contract Template (with changes approved by AH Legal) is not used.
5. Asset Purchase Arrangement
 - PART, if less than \$100,000
 - BCC, if greater than \$100,000

Established Physician Clinic Arrangement

1. Physician Arrangements in which TCC is at or above the 75th percentile of the relevant benchmark.
2. Physician Arrangements in which the compensation model utilizes a compensation per wRVU conversion factor that exceeds the 60th percentile of compensation per wRVU of the relevant benchmark.
3. The Physician specific annual subsidy exceeds 100% of the Physician's TCC, or the Physician's annual Clinical Compensation exceeds 80% of annual professional collections attributable to the Physician's professional services.
4. Physician Arrangements wherein the Physician meets the definition of a "disqualified person" under the I.R.S. regulations.
5. The Physician Contract Template (with changes approved by AH Legal) is not used.

Acquired Physician Clinic Arrangement

1. Physician Arrangements in which the initial year's TCC is at or above the 75th percentile of the relevant benchmark.
2. Physician Arrangements in which the compensation model utilizes a compensation per wRVU conversion factor that exceeds the 60th percentile of compensation per wRVU of the relevant benchmark.
3. Physician Arrangements wherein the Physician meets the definition of a "disqualified person" under the I.R.S. regulations.
4. The Physician Contract Template (with changes approved by AH Legal) is not used.

Physician Recruitment Arrangements, as provided for in the AH Physician Recruitment Policy.

Hospital Based Physician Arrangements (such as Radiology, ED, Anesthesiology, Pathology, Hospitalist) with FTE compensation greater than the 75th percentile set forth in the latest MGMA survey results.

Space Leases with a term of five years or more.

Teaching Services Arrangements (all)

Loans and Lines of Credit (all)

b. Timing of Full Reviews

Full Reviews must be completed prior to execution of any Physician Arrangements contract and before the Physician begins providing any services. PART will meet biweekly to review complete and accurate Packages. PART will make its recommendation to BCC immediately following their review. BCC will attempt to review the Physician Arrangement and respond to the Facility within a maximum of three weeks from the Facility's initial submittal of the complete Package. PART is available for consultation throughout the Physician Arrangements development and review process.

2. Limited Reviews

Limited Reviews involve review of the arrangement by AH Legal and PART prior to execution and before the Physician begins providing any services. PART will complete its review within eight days of receipt of the submission of a complete and accurate Package that has been reviewed by AH Legal. Required materials for the Limited Reviews are included in the Package, except that PART will not receive or review Facility Business Plan Pro Formas. PART can refer any Limited Review Physician Arrangement to BCC for review.

a. Types of Physician Arrangements Requiring a Limited Review

Physician Arrangements that require a Limited Review are arrangements with one or more of the following features:

1. Clinic Arrangements with a yellow PCAT score
2. Hospital Based Physician Arrangements (such as Radiology, ED, Anesthesiology, Pathology, Hospitalist) with FTE compensation greater than the median in the latest MGMA survey results
3. Administrative Services Arrangements with an hourly rate greater than the relevant rates set forth in Section II.B

4. Call Coverage Arrangements with a yellow or red PCAT score
5. Physician Recruitment Arrangements as provided for in the AH Physician Recruitment Policy
6. Space Leases with a term between three and five years
7. Miscellaneous Physician Arrangements (that are not described in Section II above) with annual compensation above \$5,000

3. **Express Reviews**

Physician Arrangements that do not require a Full Review or Limited Review are eligible to be processed as an Express Review. Required materials for the Express Reviews are included in the Package. Upon receipt of approval of the Physician Arrangement from AH Legal and the Regional CFO, a Facility can execute the Physician Arrangement contract(s). AH Legal can refer any Express Review Physician Arrangement to PART for review.

AH Compliance will regularly audit each Facility's Physician contract files to ensure adequate and proper documentation, as required by this Policy, is included within the files. Any Facility that fails to properly maintain documents associated with an Express Review, or that fails to execute documents in a form approved by AH Legal, may be directed by PART to submit all future Physician Arrangements through the Limited or Full Review process.

Exhibit A: Physician Compensation Assessment Tool (PCAT)

Physician Compensation Assessment Tool v2015_06_24_1707.xlsx - Excel

PCAT INPUT (1 of 2)
REPORT DATA SOURCES:

PCAT INPUT
DOCUMENTATION & APPROVAL
PCAT REPORT
BENCHMARK COMPARISON
CALL PAY CALCULATOR

2015_06_24_17
07

GENERAL INFORMATION

PHYSICIAN NAME Reset All Tabs

FIRST NAME	LAST NAME	TITLE	ORIGIN

AHS ENTITY NAME

FACILITY DATE OF HIRE (MM/DD/YYYY)

ADJUSTER, PARTIAL FTE/YEAR (0 to 1) Full Time

IS THIS A PRODUCTION PSA CONTRACT No

STANDARD AH PROFESSIONAL SERVICE AGREEMENT TEMPLATE

IS THIS A STANDARD CONTRACT BEING USED WITHOUT ANY MODIFICATION?

BENCHMARK FILTERS (SELECT BENCHMARK FOR REPORT BY) Survey Blend

COMPENSATION CALCULATION

MGMA (MEDICAL GROUP MANAGEMENT ASSOCIATION)

SPECIALTY

REGION National

YEAR (OF SURVEY DATA) 2013

AMGA (AMERICAN MEDICAL GROUP ASSOCIATION)

SPECIALTY

REGION National

YEAR (OF SURVEY DATA) 2013

S&C (SULLIVAN COTTER)

SPECIALTY

REGION National

YEAR (OF SURVEY DATA) 2013

PHYSICIAN DATA

	Physician Data	Adjusted Physician Data	# of Physicians	%ile of Survey Blend	% of Survey Blend Median	% of Survey Blend 75th %tile	25th %tile	Median	60th %tile	75th %tile	90th %tile
COMPENSATION & PRODUCTIVITY											
1. TOTAL CASH COMPENSATION	\$ -	\$ -		< 10th %tile	0%	0%					
2. CONTRACTED BASE COMPENSATION	\$ -	\$ -									
3. CONTRACTED BONUS (SIGNING)	\$ -	\$ -									
4. PROJECTED BONUS (INCENTIVE)	\$ -	\$ -									
5. CONTRACTED OTHER (READS, ETC.)	\$ -	\$ -									
6. CONTRACTED ADMIN (MED. DIR. PAY, ETC.)	\$ -	\$ -									
7. CONTRACTED CALL PAY	\$ -	\$ -									
8. PROF. COLLECTIONS (2014 FY/2014 ANN)	\$ -	\$ -		< 10th %tile	0%	0%					
9. VISITS (FHC Only)											
10. NET VRVU (2014 FY/2014 ANN)				< 10th %tile	0%	0%					
11. CLINICAL COMPENSATION	\$ -	\$ -									
12. CLINICAL COMPENSATION PER VISIT (FHC Only)											
13. CLINICAL COMPENSATION PER NET VRVU	\$ -	\$ -		< 10th %tile	0%	0%					
14. CLINICAL COMPENSATION TO PROF. COLLECTIONS R				< 10th %tile	0%	0%					
15. PROF. COLLECTIONS PER NET VRVU	\$ -	\$ -		< 10th %tile	0%	0%					

PHYSICIAN FINANCES (2014 FY/2014 ANN)

NET INCOME (LOSS)/SUBSIDY

COMMERCIAL REASONABLENESS RATIOS

16. CLINICAL COMPENSATION AS PERCENT OF PROF. CO

17. NET LOSS/SUBSIDY AS PERCENT OF CLINICAL COMPE

COMMENTS ON INPUTS PROVIDED (UNIQUE OR UNUSUAL CIRCUMSTANCES)

FOOTNOTES:

(1) This report utilizes the "Physician Compensation > 1Yr" benchmark from MGMA

(2) This analysis assumes that physicians are coding at the appropriate levels

(3) AMGA does not report data for the following specialties: OB/GYN, Family Medicine, Geriatrics, Hematology/Oncology, Hospitalist, Infectious Disease, Internal Medicine, Interventional Radiology, Medical Oncology, Nephrology, Neurology, Nuclear Medicine, Pathology, Pediatrics, Plastic Surgery, Radiation Oncology, Rheumatology, Sports Medicine, Urology, and Vascular Medicine

(4) Clinical Compensation is comprised of Base Compensation, Bonus (Signing), Bonus (Incentive), and Other

(5) ⚠ This warning sign becomes visible when the specialty selected differs from the pre-populated specialty

Exhibit B: Call Pay Calculator

Call Pay Calculator

REPORT DATA SOURCES:
MGMA: 2014 Report Based on 2013 Data
AMGA: 2014 Report Based on 2013 Data
Sullivan Cotter: 2014 Report Based on 2013 Data

PCAT INPUT

DOCUMENTATION & APPROVAL

PCAT REPORT

BENCHMARK COMPARISON

SPECIALTY BLEND

CALL PAY CALCULATOR

AHS Entity Name:

Physician Survey Blend Specialty:

Year (of Survey Data):

Primary Contact Name:

Phone Number:

Date Entered:

On Call Selections	Rational
Response Time <input type="text" value="Information not available"/>	<input type="text" value="<< Insert Text Here >>"/>
Frequency of Call Shifts <input type="text" value="Information not available"/>	<input type="text" value="<< Insert Text Here >>"/>
Frequency of On Call Events Per Call Shift (12 Mths) <input type="text" value="Information not available"/>	<input type="text" value="<< Insert Text Here >>"/>
Indigent % of Payor Mix (12 Mths) <input type="text" value="Information not available"/>	<input type="text" value="<< Insert Text Here >>"/>

SCORING CRITERIA

Response Time	Score	%	Adjusted Score
0	20.0%	0.00	
0	25.0%	0.00	
0	25.0%	0.00	
0	30.0%	0.00	
Total	0	100.0%	0.00

BENCHMARK

MGMA Average Hours	# of Physicians	Mean	25th %tile	Median	75th %tile
<input type="text" value="2,000"/>	20,158	\$ 233,779	\$ 180,616	\$ 216,976	\$ 267,671
Calculated Hourly Rate	\$	117	\$ 90	\$ 108	\$ 134

PROJECTED CALL PAY

% Factor	Score	Range of Compensation for 24 Hours		
		Low	Medium	High
10% Factor	0.00 - 2.25	\$ 217	\$ 260	\$ 321
15% Factor	2.26 - 3.85	\$ 325	\$ 391	\$ 482
20% Factor	3.86 - 5.00	\$ 433	\$ 521	\$ 642

FOR CONTRACT REVIEW TEAM ONLY

PCRC DISCRETIONARY ADJUSTMENT

Increase %	Max Contract Rate
<input type="text" value=""/>	<input type="text" value=""/>

PCRC DISCRETIONARY ADJUSTMENT RATIONAL

Summary

The Call Factor is 10%. The range of compensation for 24 hours of call is \$217 to \$321.

Proposed Contract Rate

Exhibit C: Facility Business Plan Pro Forma

Exhibit D: Physician Practice Pro Forma



Physician Pro Forma
Version as of 5.12.2015

Collaborate Link:

<https://collaborate.ah.org/share/page/site/physician-compensation-assessment/document-details?nodeRef=workspace://SpacesStore/3713117f-85e1-4fd8-a965-959aac29ff2>

Summary

Provider Specialties	
Provider(s)	
Provider Type(s)	
Provider FTEs	
Clinic Model	
Employment Model (Professional Group)	
Start Date	
Hospital	
Prepared By:	
Date:	
1st Review By:	
Date:	
2nd Review By:	
Date:	
3rd Review By:	
Date:	

The version will change as updates are made

Exhibit E: Physician Arrangement Approval Flow Matrix

Physician Arrangement Process Flow Matrix													
Arrangement	PCAT	Independent	Pro Forma	Local	Local	Regional	AHPS	Corp Legal	Corp Comp	PART		Legal	
		FMVOpinion Required	(PHY & HOSP)	Contract Analyst	CFO	CFO	CFO			Review Team	BCC		Board
NEW													
PSA / PRA / PEA													
Yes	Yes	N	Y	Y	Y	Y	Y	Y	Y	N	N	N	
Yes	Yes	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N	
Yes	Yes	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	
ACQUIRED													
Yes	Yes	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	
Yes	Yes	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	
Yes	Yes	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	
ESTABLISHED													
Yes	Yes	N	N	Y	Y	Y	Y	Y	Y	N	N	N	
Yes	Yes	N	N	Y	Y	Y	Y	Y	Y	Y	N	N	
Yes	Yes	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	
AMENDMENT													
Yes	Yes	N	N	Y	Y	Y	Y	Y	Y	N	N	N	
Yes	Yes	N	N	Y	Y	Y	Y	Y	Y	Y	N	N	
Yes	Yes	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	
OTHER													
On Call Arrangements	Yes	Y/N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Admin Services/MDA (>\$150/hr)	Yes	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Medical Office Lease <5 years	No	JLL	N	Y	Y	Y	Y	Y	Y	Y	N	N	N
Medical Office Lease 5-10 yrs.	No	JLL	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Medical Office Lease > than 10 yrs.	No	JLL	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Teaching Services Agreement	No	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
Loan & Line of Credit	No	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Equipment Lease	No	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N
Mtg Arrangements	No	N	N	Y	Y	N	Y	Y	Y	N	N	N	N
Locum Agreement	No	N	N	Y	Y	N	Y	Y	Y	N	N	N	N
Other Less than 5k/year	No	N	N	Y	Y	N	Y	Y	Y	N	N	N	N

Exhibit F: Physician Arrangements Review Package

Package will consist of at least the following updated with proposed terms:

- ✓ **Draft contract (Word version)**
- ✓ **Physician Compensation Assessment Tool (if required in the Matrix)**
- ✓ **Physician Practice Pro Forma (if required in the Matrix)**
- ✓ **Facility CEO Attestation**
- ✓ **FMV documentation**
- ✓ **Documentation of Matrix-required approvals**
- ✓ **W-9**

REFERENCES:

CALIFORNIA:
HAWAII:
OREGON:
WASHINGTON:

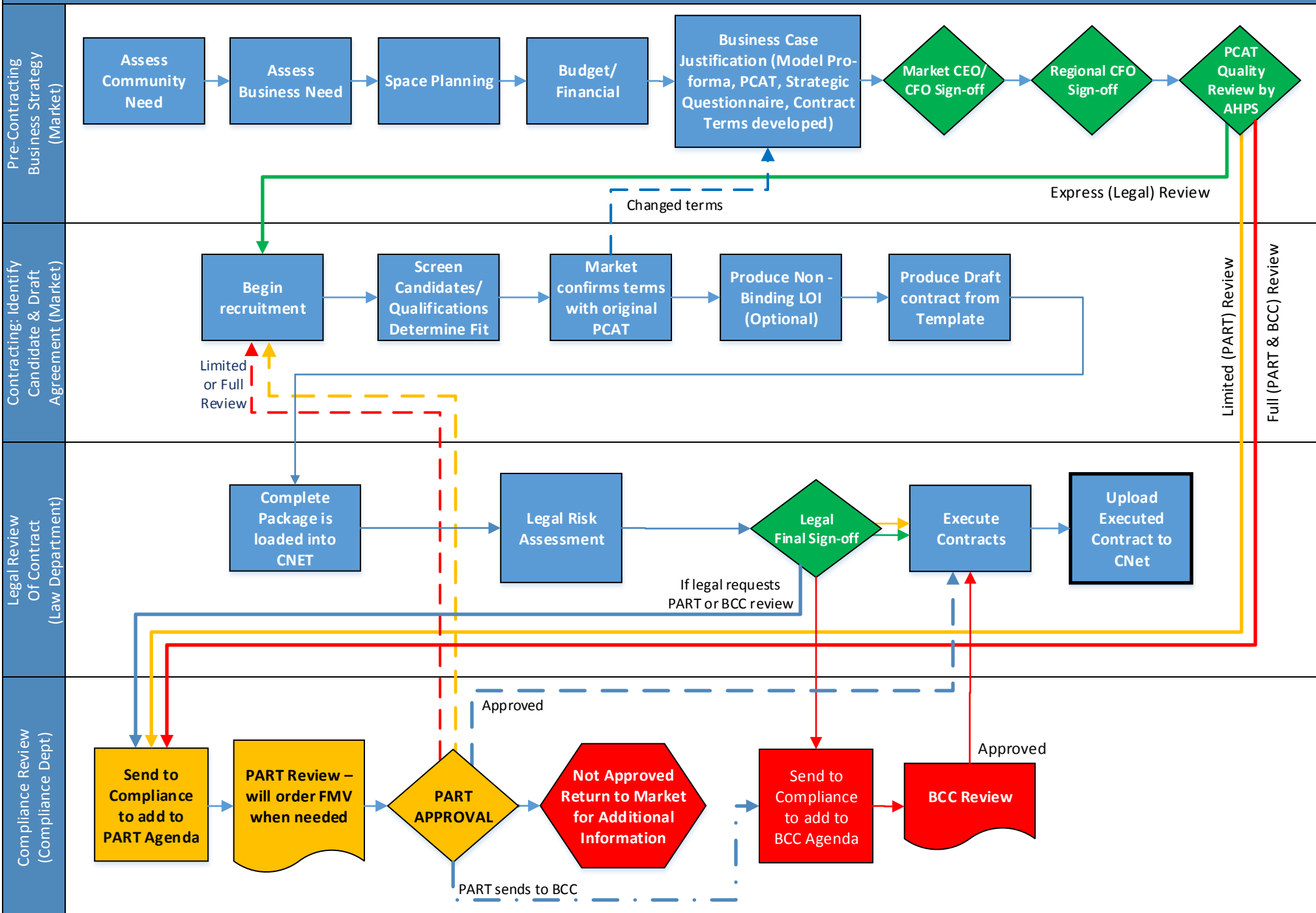
AUTHOR:
SITE SPECIFIC POLICY OWNER:
HOSPITAL SPECIFIC COLLABORATION:

APPROVED BY:
CORPORATE: Adventist Health Board of Directors 9-15-15
HOSPITAL [name of approval committee, date approved]:

REVIEW DATE:
REVISION DATE:
ATTACHMENTS:
DISTRIBUTION TO:

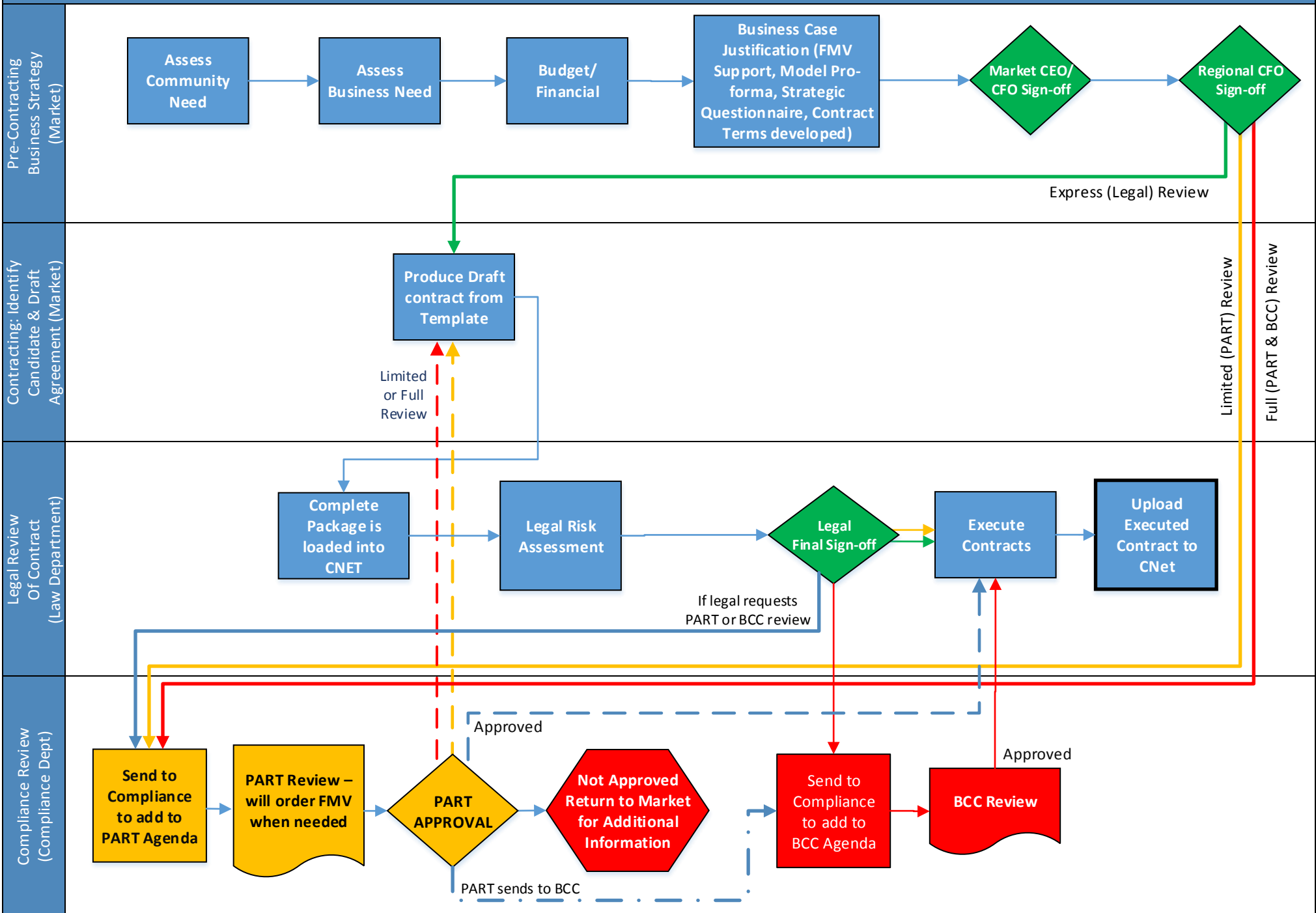
Physician Arrangements Review Process Flowchart (with PCAT)

(1/21/16)



Physician Arrangements Review Process Flowchart (without PCAT)

(1/21/16)



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.

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 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.

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.

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

² See Provider Reimbursement Manual Section 2113 for further guidance.

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-

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 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

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.

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.

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 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 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.

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.

(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

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

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.

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

[Add Model Hospice Medical Director Agreement]

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

**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 6

**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.

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.

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 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.⁺

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 fiscal 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.

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.

a. Requisition Design.

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 each ordered 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 multichannel 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 should 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.

(1) **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.

(2) **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 diagnoses obtained from the physician to ICD-9CM codes.

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.

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

(3) 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 or an appropriate verbal order 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.⁵

(4) Billing of Automated Multichannel Chemistry Tests.

Each AH-affiliated laboratory should ensure that it bills Medicare appropriately for automated multichannel 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) Billing of Calculations.

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.

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.

(6) 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.⁶

(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);

(b) where the procedure is for non-FDA approved tests;
and

⁶ As necessary, the physician should obtain one ABN per test ordered.

(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.⁷

(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 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.

⁷ 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.”

(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:

- (i) obtain an ABN after Medicare has denied payment for a submitted claim; or
- (ii) 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 within one (1) year 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 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.

Finally, with respect to end stage renal disease ("ESRD") patients, at least once per year, 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 will help decrease the likelihood that the government will view the laboratory's conduct as problematic under the federal 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 records⁸) 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.

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,

⁸ 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.

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.

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.⁹ 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 11 hereto.

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.

⁹ See Attachment 2 of the Legal Compliance Program for a sample employee acknowledgment form.

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.¹⁰

D. CLIA

Each AH-affiliated laboratory should ensure compliance with applicable CLIA or state law requirements¹¹, including, (1) obtaining and maintaining the appropriate CLIA certificate based on the types of tests performed by the laboratory;¹² (2) ensuring that each laboratory is under the overall management of a qualified laboratory director;¹³ (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

¹⁰ However, see Section L1, below (labs operating in California may not place their phlebotomists in physician offices under California state law).

¹¹ Washington and Oregon are exempt from the conditions of participation requirements of CLIA, because their state laws for clinical laboratory certification are at least as stringent as CLIA's.

¹² 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.

¹³ 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).

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.¹⁴

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.

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.

¹⁴ If the AH laboratory is acting as a reference lab, it may look to the hospital for payment for its services.

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.¹⁵

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

¹⁵ 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.

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.¹⁶ 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.¹⁷

b. Persons authorized to Order Tests: Laboratories may only accept assignment for tests and only make reports to physicians, dentists, or other persons

¹⁶ 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.

¹⁷ 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.

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 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.¹⁸

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.

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.

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.

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.¹⁹

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).

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.

- 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.
- 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.²⁰ 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 Medicaid only for a venipuncture or a catheterization for a urine sample where a specimen is referred to an outside lab. No further handling or specimen charge may be billed.
- 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

²⁰ 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.

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
- 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

<p style="text-align: center;">LABORATORY OUTPATIENT LAB REQUESTS FORM</p> <p><input type="checkbox"/> STAT <input type="checkbox"/> CALL RESULTS BY: _____ <input type="checkbox"/> FAX RESULTS TO FAX #: _____</p> <p>COLLECTION INFORMATION: Date: _____ Time: _____ By: _____ Comments: _____ _____ _____</p>	<p style="text-align: center;">TO BE FILLED OUT BY PHYSICIAN'S OFFICE</p> <p>CLINIC: _____ PATIENT: _____ MED RED # _____ DOB: ____/____/____ BILLING # _____</p> <p>ONE BOX MUST BE MARKED <input type="checkbox"/> PRIVATE PAY <input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE</p> <p style="text-align: right;">_____ REFERRING PHYSICIAN M.D.</p> <p>ICD-9 CODE(S)***: _____ _____</p>
--	---

- HEMATOLOGY**
- CBC, w/platelets, w/auto diff.
 - Hemogram, w/platelets
 - Reticulocyte Count
 - Sed Rate – Westergren

- COAGULATION**
- Draw Site _____
- PT – Prothrombin Time
 - PTT – Partial Thromboplastin
 - Fibrinogen
 - Bleeding Time

- MICROBIOLOGY**
- Specimen Source _____
- Gram Stain
 - Direct AFB Stain
 - Culture, Aerobic
 - Culture, Anaerobic
 - Culture(s) Blood x _____
 - Culture, Genital
 - Culture, Strep Group B
- Screen (vaginal, cervical & placental only)
- Culture, Stool
 - Culture, Throat
 - Culture, Urine
 Clean Catch
 Cath Type _____
 - Culture, VRE Screen

- REFERRED MICROBIOLOGY**
- Specimen Source _____
- Culture, AFB includes AFB Stain
 - Culture, Fungal
 - Culture, Herpes
typing 2649 _____
without typing 2693 _____
 - Culture, Mycoplasma
 - Culture, Viral
 - Genprobe for Chlamydia & GC

- SPECIAL MICROBIOLOGY**
- Beta Strep
 - KOH Prep
 - Wet Mount
 - Occult Blood
 - Stool Screen
 - Stool WBC
 - Ova & Parasites x _____

- GLUCOSE TOLERANCE TESTING**
- 1 Hr Glucose 50 gm challenge
 - 2 Hr GTT 75 gm (non-pregnant)*
 - 3 Hr GTT 100 gm (prenatal only)*
 - 2 Hr Post Prandial
 - 2 Hr Post 75 gm glucola

- URINALYSIS**
- Urinalysis: Culture if indicated
 - Urinalysis: No Culture
 - Spec. Type
 Clean Catch
 No Clean Catch
 Temporary Catheter
 Indwell Catheter _____

Inserted on _____ at _____
Date Time

- AMA CPT PANELS**
- Basic Metabolic Panel 80049**
Carbon dioxide (bicarbonate)(82374)
Chloride; blood (82435)
Creatinine; blood (82565)
Glucose; quantitative (82947)
Potassium; serum (84132)
Sodium; serum (84295)
Urea nitrogen; quantitative (84520)
 - Comprehensive Metabolic Panel 80054**
Albumin; serum (82040)
Bilirubin; total (82250)
Calcium; total (82310)
Chloride; blood (82435)
Creatinine; blood (82565)
Glucose; quantitative (82947)
Phosphatase; alkaline (84075)
Potassium; serum (84132)
Protein; total. Except refractometry (84155)
Sodium; serum (84295)
Transferase; aspartate amino (AST)(SGOT)(84450)
Urea nitrogen; quantitative (84520)
 - Electrolytes Panel 80051**
Carbon dioxide (bicarbonate)(82374)
Chloride; blood (82435)
Potassium; serum (84132)
Sodium; serum (84295)
 - Hepatic Function Panel A (w/ Bilirubin, total and direct) 80058**
Albumin, serum (82040)
Bilirubin, total and direct (82251)
Phosphatase, alkaline (84075)
Transferase, aspartate amino (AST)(SGOT)(84450)
Transferase, alanine amono (ALT)(SGPT)(84460)
 - Lipid Panel**
Cholesterol, serum total (82465)
Lipoprotein, direct HDL (83718)
Triglycerides (84478)

If any individual component/test included in the above panels is not, in your professional medical opinion, medically necessary for your patient, you must individually order only that test(s) which is (are) medically necessary from the list below.

- CHEMISTRY**
- | | |
|---|--|
| <input type="checkbox"/> Albumin | <input type="checkbox"/> Glucose – Fasting |
| <input type="checkbox"/> Alkaline Phosphatase | <input type="checkbox"/> Glucose – Random |
| <input type="checkbox"/> ALT/GPT | <input type="checkbox"/> GGT |
| <input type="checkbox"/> Amylase | <input type="checkbox"/> HDL Cholesterol |
| <input type="checkbox"/> AST/GOT | <input type="checkbox"/> Iron |
| <input type="checkbox"/> Bilirubin, Direct | <input type="checkbox"/> LDH |
| <input type="checkbox"/> Bilirubin, Total | <input type="checkbox"/> Magnesium |
| <input type="checkbox"/> Bun | <input type="checkbox"/> Phosphorus, Inorganic |
| <input type="checkbox"/> Calcium | <input type="checkbox"/> Potassium |
| <input type="checkbox"/> Chloride | <input type="checkbox"/> Protein, Total |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Sodium |
| <input type="checkbox"/> CO ₂ | <input type="checkbox"/> TIBC |
| <input type="checkbox"/> CPK | <input type="checkbox"/> Triglyceride |
| <input type="checkbox"/> Creatinine | <input type="checkbox"/> Uric Acid |
| <input type="checkbox"/> Ferritin | <input type="checkbox"/> % Saturation |

Other: _____

- SPECIAL CHEMISTRY**
- Last Dose:
Date _____ Time _____
- Carbamezepine (Tegretol)
 - Digoxin
 - Dilantin (Phenytoin)
 - Phenobarbital
 - Quinidine
 - Theophylline
 - Valporic Acid
 - Acetaminophen (Tylenol)
 - Blood Alcohol (Medical)
 - Salicylate
- Urine Drug Screen
- Medical - Routine (SKBL #2180)
 - Chain of Custody (SKBL #70180)
 - Glycated Hemoglobin/HgbA1C
 - FSH
 - LH
 - HCG (Quant)
 - CEA
 - PSA
 - T4 (Free)
 - TSH (Highly Sensitive)

- BLOOD BANK**
- Type (ABO)
 - Rh (D)
 - Antibody Screen (Rh Titer)
 - Direct Coombs
 - Type & Screen
 - Type & Hold _____ units
 - Crossmatch _____ units
 Packed RBCs
 Direct Donors
 Autologous

DATE OF ANTICIPATED NEED _____
DATE OF LAST TRANSFUSION _____

- SEROLOGY**
- Mono
 - RA (Rheumatoid Factor)
 - RPR
 - Rubella
 - Hepatitis B Surface Antigen
 - Hepatitis B Surface Antibody
 - Hep C AB
 - Hepatitis A & B Diagnostic plus C (SBCL #6462)
 - HIV (SKBL #6449)

MISCELLANEOUS

* By appointment only
** Fasting Preferred
*** Note: You must insert one (1) diagnosis code per test/panel ordered.

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 multichannel 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. Medicare may deny payment for tests ordered for screening purposes only.

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 multichannel 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>
Profile X	ferritin chloride iron			

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:

(1) that you have requested the creation of each custom profile listed on Attachment 1;

(2) that you have requested each individual test indicated on Attachment 1 to be included in each such profile;

(3) 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;

(4) 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;

(5) 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;

(6) 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;

(7) 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

(8) [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:

Please Indicate the Specific Test(s):	
<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:

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. this procedure because it is not reasonable or necessary under current Medicare guidelines 2. screening tests. 3. non-FDA approved tests. | <ol style="list-style-type: none"> 4. the test indicated above because the federal Medicare carrier has indicated that is not covered for your reported condition. 5. <i>[Add additional explanations for likely denial by Medicare]</i> |
|--|--|

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 Generally²¹

- 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.***

²¹ 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 testing²²

- (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 testing²³

- (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.

²² The regulations for blood alcohol testing are at Hawaii Administrative Rules ("H.A.R.") chapter 11-114.

²³ The regulations for substance abuse testing are at H.A.R. chapter 11-113.

- (4) *Unless otherwise instructed in writing, all records pertaining to a given specimen shall be retained by the laboratory for a minimum of two years.*
- (5) *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.*
- (6) A retest is not subject to a specific cutoff requirement but must provide data sufficient to confirm the presence of the drug or metabolite.
- (7) 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.²⁴

- (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.
- (6) Release is made to the patient's health care insurer to obtain reimbursement for services rendered to the patient; provided that release

²⁴ The requirements with respect to HIV records are contained primarily in Hawaii Revised Statutes section 325-101.

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 COMPLIANCE PROGRAM
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 Compliance Program which formalizes our compliance efforts into a comprehensive program which better defines the responsibilities of all AH employees compliance issues. The compliance program is divided into different parts that address general compliance policies and procedures, physician contracts, Home Health & Hospice, Laboratory, Health Information Management, Patient Financial Services, Hospital Based Clinics, and Rural Health Clinics.

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

Each AH-affiliated affected department will receive a copy of its respective part of the compliance program. In addition, specific departmental training program will help ensure that affected employees understand the standards of conduct that they are expected to follow.

The 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 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.

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

Board Adopted July 10, 1998, revised September 9, 1998, January 31, 2013

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 the 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 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 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 Toll-free
Tel: (916) 781-4730
Fax: (916) 774-3382

[Facility Privacy Official]

[Facility]
[Address]
[City], [State] [Zip]
Tel: (xxx) xxx-xxxx
Fax: (xxx) xxx-xxxx

[Facility IT Security Official]

[Facility]
[Address]
[City], [State] [Zip]
Tel: (xxx) xxx-xxxx
Fax: (xxx) xxx-xxxx

**ADVENTIST HEALTH
COMPLIANCE PROGRAM
ACKNOWLEDGMENT OF RECEIPT AND REVIEW**

A copy of the Compliance Program that applies to my department has been made available to me and I agree to abide by the policies, rules and regulations contained therein.

I understand that this department's 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**

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The 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 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.

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

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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 the 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 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 Compliance Program.

Local Compliance Officer

[Hospital]
[Compliance Officer Name]
[Address]
[City, State Zip]
Tel: (XXX) XXX-XXXX

Facility Privacy Officer

[Hospital]
[Compliance Officer Name]
[Address]
[City, State Zip]
Tel: (XXX) XXX-XXXX

Facility Security Officer

[Hospital]
[Compliance Officer Name]
[Address]
[City, State Zip]
Tel: (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) 774-338

Corporate Compliance Program, Part 5

Revised May 2006

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Attachment 2

ADVENTIST HEALTH
COMPLIANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT AND REVIEW

A copy of the Compliance Program that applies to my department has been made available to me and I agree to abide by the policies, rules and regulations contained therein.

I understand that this department's 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

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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.

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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.
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
1. General Issues:			
<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>	_____	_____	_____
2. Office equipment usage:			
<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>	_____	_____	_____
3. Software programs/systems			
<i>Master Patient Index</i>	_____	_____	_____
<i>Chart deficiency</i>	_____	_____	_____
<i>Unit consolidation/duplicate MR#</i>	_____	_____	_____
<i>Release of information</i>	_____	_____	_____
4. Tour of facility			
	_____	_____	_____

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5. Tour of department _____

6. Quality improvement activities _____

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.

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.

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 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.

Revised November 30, 2000; 5/16/05

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

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.

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 specially trained personnel 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

ADVENTIST HEALTH 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 its 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 (____-____-____).
- **HIPAA Privacy Official** - Currently the HIPAA Privacy Officer is [*INSERT NAME OF HIPAA PRIVACY OFFICER*], who can be reach at (____-____-____).
- **IT Security Official** - Currently the IT Security Officer is [*INSERT NAME OF IT SECURITY 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.

September 13, 1999

**ADVENTIST HEALTH
Corporate Compliance Program**

PART 7: Hospital-based outpatient clinics

INTRODUCTION

Adventist Health (“AH”) has established the following policies and procedures for the hospital-based outpatient 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-based outpatient 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-based outpatient clinics.

While these policies and procedures highlight federal and state laws specific to hospital-based outpatient clinics, they do not include every legal requirement that applies to hospital-based outpatient clinics. Thus, each AH organization must ensure that its hospital-based outpatient 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-based outpatient clinic operations.

Each AH-affiliated hospital-based outpatient 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 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-BASED OUTPATIENT 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-based outpatient 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-based outpatient 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-based outpatient clinics:

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.

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.

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-based outpatient 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-based outpatient 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-based outpatient 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-based outpatient 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 Physicians Network
COMPLIANCE PROGRAM**

In Development

May 31, 2005

**ADVENTIST HEALTH
Corporate Compliance Program**

PART 9: Rural Health Clinics

INTRODUCTION

Adventist Health (“AH”) has established the following policies and procedures for the hospital owned Rural Health Clinics in its effort to ensure compliance with applicable state and federal laws.

This Part 9 of the Compliance Program establishes AH’s policies and procedures regarding compliance with laws specific to hospital owned Rural Health 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 Rural Health Clinics.

While these policies and procedures highlight federal and state laws specific to hospital owned Rural Health Clinics, they do not include every legal requirement that applies to hospital owned Rural Health Clinics. Thus, each AH organization must ensure that its hospital owned Rural Health Clinic or Clinics are in compliance with all laws, regulations and other applicable federal and state government and other regulatory 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 Rural Health Clinic operations.

Each AH-affiliated hospital owned Rural Health 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 administrator, local compliance officer, and AH’s Corporate Compliance

Officers 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 RURAL HEALTH 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 Rural Health 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 Rural Health 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 Rural Health 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 Rural Health Clinics is to provide high quality, cost-effective health care services to low-income 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.

AH expects its individual Rural Health Clinics to meet all state requirements regarding supervision and documentation of supervision of mid-level providers by qualified physician(s).

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 Rural Health 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 Rural Health Clinics may 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 a government entity. 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. AH Rural Health Clinics will only bill patient contacts that qualify as face-to-face visits. 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. **Continuing Eligibility for Rural Health Clinic Certification**

AH will only provide Rural Health Clinic services in locations that meet all federal and state requirements for Rural Health Clinic certification.

AH Clinic Services will monitor HPSA and MUA designations and urban/rural status to ensure that all AH Rural Health Clinics maintain their certifications or plan appropriately in the event that de-certification is unavoidable.

8. **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.

9. **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.

10. **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 9 of the Compliance Program establishes AH's policies and procedures regarding compliance with laws and issues specific to hospital owned Rural Health 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
Corporate Compliance Program
Part 10: Patient Financial Services/Registration
Checklist

Actions relating to the Compliance Program Specifically:

- _____ Review the compliance program with PFS/RA (Registration Assistant) personnel annually.
- _____ Have the PFS/RA staff perform online, the T.R.A.I.N. Module annually.

Actions required by the Compliance Program Concerning Operations:

Definitions:

- _____ Identity Theft means the act of: knowingly obtaining, possessing, buying, or using the personal identifying information of another: (i) with the intent to commit any unlawful act including, but not limited to, obtaining or attempting to obtain credit, goods, services or medical information in the name of such other person; and (ii)(a) without the consent of such other person; or (b) without the lawful authority to obtain, possess, buy or use such identifying information.
- _____ Theft of Services includes: (i) intentionally obtaining services by deception, fraud, coercion, false pretense or any other means to avoid payment for the services; and (ii) having control over the disposition of services to others, knowingly diverts those services to the person's own benefit or to the benefit of another not entitled thereto.
- _____ Unit/Account Notes includes: Unit note documentation can be added by entering standard or free-text notes. Since unit notes follow a person, they are used to convey information that registration personnel need to know. Unit notes automatically display at the beginning of the registration process

General Policies & Procedures:

- _____ Adhere to state and federal licensing requirements & Medicare conditions of participation.
- _____ The AH hospitals and affiliates will not discriminate against patients.
- _____ Inform patients of termination of services when ID theft is discovered.
- _____ Inform supervisor, department head, administration, security, and/or local law enforcement authorities when ID theft has been identified.

Training & Education:

- _____ All staff will be trained concerning federal and state regulations, Corporate policies and procedures, and specific departmental requirements.
- _____ PFS/RA 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.

The department will follow state, federal and AH Corporate Compliance guidelines regarding patient/medical identity theft documentation.

Adventist Health
Corporate Compliance Program
Part 10: Patient Financial Services/Registration
Checklist

Release of Information:

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

November 1, 2008

**ADVENTIST HEALTH
Corporate Compliance Program**

PART 10: PATIENT IDENTITY PROTECTION

I.

INTRODUCTION

Effective November 1, 2008, all federally regulated banks, credit card companies and other institutions offering credit, including healthcare organizations, will be required to be in full compliance with the Identity Theft Red Flags Rule, which is designed to protect consumers' identity.

The goal of the rule is to "flag" attempted and actual identity theft early, thereby reducing consequences associated with identity theft. It should be pointed out that the Federal Trade Commission (FTC) does not have jurisdiction over not-for-profit organizations when the organizations are acting in their not-for-profit capacity; however, the American Hospital Association (AHA) takes the position that not-for-profit organizations are subject to the FTC's jurisdiction much like a for-profit entity would be. For example, where any entity or government institution defers payment for goods or services, they are to be considered creditors. Therefore, the FTC takes the position that a not-for-profit organization such as a hospital or other healthcare provider that collects payment information from patients in order to bill them for services rendered falls into the category of creditor and these facilities are required to comply with the rule.

Medical identity theft occurs when someone uses a person's name or other identification information – such as insurance information – without the person's knowledge or consent to obtain medical services or goods, or uses the person's identity information to make false claims for medical services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records, and can involve the creation of fictitious medical records in the victim's name.

Medical identity theft is a crime that can cause great harm to its victims. It is also the most difficult to fix after the fact, because victims have limited rights and remedies. Medical identity theft typically leaves a trail of falsified information in medical records that can plague a victim's medical and financial life for years.

The corporate compliance department is responsible for helping each AH institution develop, maintain, educate, train, and provide the necessary tools to adopt policies and procedures for detecting, preventing and mitigating identity theft. Further,

the compliance department developed this program, which includes a list of red flag activities or behaviors that signal possible identity theft and recommends a response when a red flag is identified. In addition, the compliance department is responsible for updating the program periodically to reflect changes in risks from identity theft and to maintain an internal compliance program as part of its efforts to comply with the Identity Theft Red Flags regulation.

AH facilities are expected to follow the policies and procedures, developed in response to the ID Theft Red Flags regulation to protect the security of their business and their patients from identity thieves.

II.

INTENT

It is the intent of this policy to provide guidance and oversight to Adventist Health (AH) member hospitals, home health agencies, clinics, outpatient pharmacies, and other health care affiliates within AH to protect the identity of all patients that seek medical treatment either as inpatient, outpatient or emergency patient.

III.

POLICIES AND PROCEDURES FOR PATIENT IDENTITY PROTECTION

A. Definitions

1. Financial Institution – state or national bank, a state or federal savings & loan association, a mutual savings bank, a state or federal credit union, or any other entity that holds a “transaction account” belonging to a consumer.

2. Transaction Account – is a deposit or other account to which the owner makes payments or transfers. Transaction accounts include checking accounts, negotiable order of withdrawal accounts, savings deposits subject to automatic transfers, and share draft accounts.

3. Creditor – is any entity that regularly extends, renews or continues credit. Accepting credit cards as a form of payment does not in and of itself make an entity a creditor. Creditors include finance companies, mortgage brokers, utility, telecommunications companies, and healthcare institutions. Where non-profit and government entities defer payment for goods or services they, too, are to be considered creditors.

4. Covered Account – an account used primarily for personal, family or household purposes. It also includes credit cards, mortgage loans, automobile loans, margin accounts, cell phone accounts, checking accounts, savings accounts, and

deferred payment accounts. A covered account is also an account for which there is a foreseeable risk of identity theft.

5. Red Flags – identification, detection and response to patterns, practices, or specific activities that could indicate identity theft. There are 26 red flag triggers that institutions should incorporate to help prevent identity theft. Section C.2, below list red flag triggers that likely impact healthcare providers.

6. Medical Identity Theft – medical identity theft is a specific type of identity theft which occurs when a person uses someone else’s personal health identifiable information, such as insurance information, Social Security Number, health care file, or medical records, without the individual’s knowledge or consent to obtain medical goods or services or to submit false claims for medical services

B. Responsible Departments

All facilities that are involved in obtaining patients’, guarantors’ and/or insurance subscribers’ consent for treatment and payment.

C. Compliance Program – Key Elements

1. Establish a Program

Establish a formal identity theft program that is designed to detect, prevent, and mitigate identity theft in conjunction with requesting patient identification at the time of service.

2. Identify Relevant Red Flags

The following list of red flags are relevant to AH facilities.

- Documents provided for identification appearing altered or forged.
- Photograph on ID inconsistent with appearance of customer.
- Information on ID inconsistent with information provided by person opening account.
- Information on ID, such as signature, inconsistent with information on file.
- Information on ID not matching any address in the consumer report, Social Security number has not been issued or appears on Social Security Administrations Death Master File.
- Lack of correlation between Social Security number range and date of birth.
- Personal identifying information associated with known fraud activity.
- Suspicious addresses supplied, such as a mail drop or prison, or phone numbers associated with pagers or answering service.
- Social Security number provided matches number(s) supplied by an other applicants.
- Personal information inconsistent with information already on file at financial institution or creditor.

- Person opening account or customer unable to correctly answer challenging questions.

3. Detect Red Flags

AH facility procedures detect the identified red flags and detect additional suspicious behaviors that also may indicate identity theft according to applicable policies and procedures. AH verifies the identity of customers, patients, guarantors, and/or insurance subscribers presenting identification.

4. Establishing Response Procedures

AH facilities follow appropriate policies and procedures to respond to any detected red flags. The response corresponds with the degree of risk posed, which may include monitoring an account, contacting the patient, guarantor, and/or insurance subscriber, changing passwords, or notifying security and/or the local law enforcement. In all events, the protected health information of both the identity thief and the identity theft victim shall be treated in accordance with applicable law.

5. Ensure the Program is Updated Periodically

AH facilities periodically review and update their program to keep current with changes in identity theft tactics and, as necessary, utilize new methods of combating identity theft.

6. Methods of Administrating the Program

The AH legal board (LB) approves the initial written program by the corporate compliance department. The LB shall delegate oversight of the implementation of the policy and procedure to the corporate compliance department.

7. Consequences of Noncompliance

Failure to comply with the Red Flags Rule can result in various penalties. Consequences may include a civil money penalty for each violation, regulatory enforcement action, and negative publicity. Although the Rule does not allow for any private legal action, there is the potential for civil litigation.

8. Documentation

AH facilities that detect suspected identity theft are required to report and document the incident in accordance with local incident reporting policies through the local risk management department. In addition the facility shall notify the local compliance officer and the corporate compliance department of any occurrences of identity theft.

9. Training and Education

AH requires that all Management, HIM, FISO, Patient Financial Services and Registration Department employees be knowledgeable regarding the regulations pertaining to the Red Flags Rule and patient/medical identity theft prevention. The proper education and training of each employee is an important element of the AH Corporate Compliance Program.

The training and education plan should include but not be limited to:

- a. Job competency testing and training to ensure an appropriate level of knowledge for specific job requirements.
- b. Regulatory compliance training in accordance with AH policy.
- c. On-going training through the use of staff meetings; training seminars; American Hospital Association (AHA), Healthcare Financial Management Association (HFMA) and government bulletins and publications; and other materials that enhance employee knowledge regarding their responsibilities and compliance education.

Training topics shall include:

1. Proper documentation and verification of patient identification/medical identity before services are rendered, including the correct procedure for collecting patient insurance, date of birth, SS# and other relevant patient ID information.
2. Who is responsible for the proper registration intake process?
3. Duty to report any suspected identity theft through the incident reporting process.
4. Specific government and compliance guidelines.

E. Miscellaneous

AH System-Wide Policies to Cross-Reference

- HIPAA Privacy Policies
 1. AD-10-001-S Patient Rights Related to Protected Health Information
 2. AD-10-003-S Minimum Necessary – Role Based Access
 3. AD-10-010-S Compliance with Business Associate Requirements
 4. AD-10-012-S Verifying Personal Identity
 5. AD-10-018-S Provider Confidentiality Agreement
 6. AD-10-019-S HIPAA Privacy and Security Workforce Sanctions
- PFS Registration Policies
 1. PFS-165 Distribution of Face Sheets
 2. PFS-127 Financial Counseling
 3. PFS-154 Medicare Bad Debt
 4. PFS-178 Bankruptcy of Third Party Payers

5. PFS/Registration – ART Manual, Chapter III, Registration Standards, pgs. 4-9
- IT Security Policies
 1. IS-1-1-03 Electronic Data Transmission
 2. IS-1-1-08 Sharing Data
 3. IS-1-1-09 Distribution & Disposal of Sensitive Information
 4. IS-1-1-10 Confidentiality of Information
 5. IS-1-1-16 Incident Response
 6. IS-1-1-18 Information Classification

APPENDIX A

The 26 Red Flags

1. A fraud alert included with a consumer report.
2. Notice of a credit freeze in response to a request for a consumer report.
3. A consumer-reporting agency providing a notice of address discrepancy.
4. Unusual credit activity, such as an increased number of accounts or inquiries.
5. Documents provided for identification appearing altered or forged.*
6. Photograph on ID inconsistent with appearance of customer.*
7. Information on ID inconsistent with information provided by person opening account.*
8. Information on ID, such as signature, inconsistent with information on file at financial institution.*
9. Application appearing forged or altered or destroyed and reassembled.
10. Information on ID not matching any address in the consumer report, Social Security number has not been issued or appears on the Social Security Administration's Death Master File.*
11. Lack of correlation between Social Security number range and date of birth.*
12. Personal identifying information associated with known fraud activity.*
13. Suspicious addresses supplied, such as a mail drop or prison, or phone numbers associated with pagers or answering service.*
14. Social Security number provided matching that submitted by another person opening an account or other customers.*
15. An address or phone number matching that supplied by a large number of applicants.
16. The person opening the account unable to supply identifying information in response to notification that the application is incomplete.

17. Personal information inconsistent with information already on file at financial institution or creditor.*
18. Person opening account or customer unable to correctly answer challenge questions.*
19. Shortly after change of address, creditor receiving request for additional users of account.
20. Most of available credit used for cash advances, jewelry or electronics, plus customer fails to make first payment.
21. Drastic change in payment patterns, use of available credit or spending patterns.
22. An account that has been inactive for a lengthy time suddenly exhibits unusual activity.
23. Mail sent to customer repeatedly returned as undeliverable despite ongoing transactions on active account.
24. Financial institution or creditor notified that customer is not receiving paper account statements.
25. Financial institution or creditor notified of unauthorized charges or transactions on customer's account.
26. Financial institution or creditor notified that it has opened a fraudulent account for a person engaged in identity theft.

Note: * = selected Red Flag that is applicable to AH affiliates.

Reference to Federal Register (16 CFR Part 681, pg. 63756)

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

Adventist Health Corporate Compliance Department generates reports monthly 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. The Corporate Compliance Department performs the preliminary research to rule out potential name matches. Names that cannot be ruled out are referred to the facility Local Compliance Officer to determine if the names listed on the reports are individuals or entities that 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 health care 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 searching the combined OIG/GSA/Medi-Cal/HI data base that the Compliance Department created and maintains on a designated Collaborate site. Ask the Compliance Department for directions on how to access that data.

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 printouts 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 printouts 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

Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security

HIPAA was enacted in 1996 to improve the efficiency of healthcare delivery by standardizing the electronic exchange of administrative and financial data and protect the security and privacy of health care information. The Adventist Health Privacy Council oversees the compliance and enforcement of HIPAA within our system.

Below are resources available for the handling of protected health information and privacy and security issues.

- Privacy Requirements and Guidelines
- Business Associates Documents and Forms
- Health Care Provider Standards
- Facility Compliance and Enforcement

These resources are available on the Adventist Health intranet site for employees at <https://connect.ah.org/site/hipaa/>. Additional privacy resources may be found on the Adventist Health website available to the general public at <http://www.adventisthealth.org/additional-information/compliance-information>.