

## Overview of Applicable Policies and Procedures--- Effective 01/01/2010

The Company has adopted and will continue to develop as necessary, billing policies and procedures to provide compliance guidelines for all applicable legal requirements. The Company has devised processes to select the procedure (CPT or HCPCS) codes that best describe the test(s) ordered and performed. The Company has also established processes to code signs, symptoms and diagnoses accurately using the appropriate ICD-9-CM diagnosis codes. Upcoding or revenue maximization through improper selection of billing or diagnoses codes is viewed by the OIG as submission of false claims and any individual found to be responsible for such activity will be subject to disciplinary action as outlined in the Company Code of Conduct.

Laboratory compliance policies and procedures are written in order to establish high quality, ethical and legal standards for the ordering, performing and billing of laboratory services. These policies have been developed by the Company for adoption by all Company hospitals and affiliates.

Additionally, the Company has developed tools, such as forms, system edits and automated monitoring, to assist the facility in following these policies.

### **REGS.BILL.006 Stat, Call Back, Stand-by and Handling Charges**

Stipulates that stat, call back, stand-by and handling charges will not be billed to Medicare, Medicaid or other federally funded programs. Requires that the Chief Financial Officer determine if stat, call back, stand-by and handling charges will be billed to non-federally-funded payers. If it is determined that stat, call back, stand-by and handling charges will not be billed; such charges should be eliminated from the chargemaster. If it is determined that these charges will be billed to non-federally-funded programs, then the procedures outlined in the policy should be performed so that these charges are not billed to federally-funded payers.

### **REGS.GEN.001 Billing Monitoring**

Provides an effective monitoring process for billing policies and procedures. This policy also requires that the results of the monitoring activities include review by a facility Oversight Group, such as the Facility Billing Compliance Committee or a subcommittee of the Facility Ethics and Compliance Committee.

### **REGS.GEN.002 Medicare – Medical Necessity**

Requires that facility personnel review requests for tests and other ancillary services to determine if such services are medically necessary according to Medicare guidelines in order to facilitate appropriate billing.

### **REGS.GEN.003 Advance Beneficiary Notice of Noncoverage**

Requires an Advance Beneficiary Notice of Noncoverage (ABN) be obtained from Medicare beneficiaries when tests or services are not medically necessary according to Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) and the facility intends to bill the patient.

### **REGS.GEN.004 Orders for Outpatient Tests and Services**

Requires that orders for outpatient tests and services be properly documented in accordance with Medicare, Medicaid and other federally funded payer guidelines. Requires that orders for outpatient tests and services be documented and include the data elements as defined in the policy. Also requires that absent specific exceptions and consistent with Federal and State law, tests and services must be provided based on the order of a physician or allied health practitioner authorized by the medical staff bylaws to order such tests and services.

### **REGS.GEN.007 Continuing Education Requirements**

Ensures that all personnel involved in billing and/or billing related services are aware of billing guidelines and regulatory changes, which may impact complete, accurate and consistent billing. Provides the minimum guidelines for completion of education hours and identifies the personnel who must complete the required hours.

### **REGS.GEN.009 Outpatient Services and Medicare Three-Day Window**

Requires that Medicare outpatient services provided before an inpatient admission be billed in accordance with Centers for Medicare and Medicaid Services (CMS) regulations. Establishes guidelines for when inpatient and outpatient claims are to be combined.

### **REGS.LAB. 002 Hematology Procedures**

Provides that hematology services be billed in accordance with Medicare, Medicaid and other federally funded payer requirements. Hematology components will be bundled to the panel level when all of the tests in the panel are ordered and performed. Hematology tests which include all components of a panel must not be "unbundled" into individual procedures.

### **REGS.LAB.003 Urinalysis Procedures**

Provides that urinalysis procedures be billed correctly in accordance with Medicare, Medicaid and other federally funded payer requirements. Urinalysis procedures must not be "unbundled" (i.e., the use of two or more CPT billing codes in lieu of one inclusive code), double billed or improperly submitted (i.e., for tests not ordered, for tests not medically necessary, etc.)

### **REGS.LAB.004 Organ and Disease Panels**

Provides that Organ and Disease panels are billed in accordance with Medicare, Medicaid and other federally funded payer requirements. Individual component tests must be bundled to the most comprehensive panel(s). Panels must not be "unbundled" (i.e., the use of two or more CPT billing codes in lieu of one inclusive code), double billed or improperly submitted (i.e., for tests not ordered, for tests not medically necessary, etc.).

### **REGS.LAB.006 Outpatient Specimen Collection**

Provides that specimen collection fees are charged and billed in accordance with Medicare, Medicaid and other federally funded payer requirements. Requires certain steps be performed to ensure venipuncture and catheterized urine specimen collection fees are billed in accordance with Medicare, Medicaid, and other federally funded programs.

### **REGS.LAB.007 Custom Profiles**

Outlines the requirements for the use of laboratory test panels and profiles so that Medicare will be billed only for those tests it considers to be reasonable and necessary. Provides that facilities may permit custom profiles at their discretion, and should they choose to use them, the profiles must be established, ordered and billed according to federal guidelines and regulations. Physicians who use custom profiles at facilities that permit their use must be advised of the medical necessity rules and of the billing implications of the profile(s) used. The physician must sign an acknowledgment form annually.

### **REGS.LAB.009 Referred Laboratory Testing**

Requires that laboratory tests referred to other laboratories be billed in accordance with Medicare, Medicaid, and other federally funded payer guidelines. Establishes specific steps to be taken and an annual review process.

### **REGS.LAB.010 Laboratory – Reflex Orders**

Requires that laboratory reflex testing be approved by the Medical Staff on an annual basis as evidenced in the Medical Executive Committee (MEC) minutes. Laboratory reflex testing must be medically necessary and only those protocols documented as approved by the MEC may be utilized. Physicians must be informed of those tests for which an approved reflex protocol exists and the implications of ordering the tests.

### **REGS.LAB.015 Technical Component of Anatomical Pathology Services for Inpatients and Outpatients**

Requires that pathology services be billed in accordance with Medicare, Medicaid and other federally funded payer requirements.

### **REGS.LAB.023 Laboratory – Client Billing Practices**

Requires that the marketing of laboratory services be conducted in an honest, straightforward and informative manner, be compliant with legal requirements and be non-deceptive. Provides that it is the responsibility of the laboratory to ensure clients fully understand the services offered, the services to be provided when tests are ordered and the financial consequences for the tests ordered. All clients doing business with a facility laboratory must sign a written agreement and the facility's operations counsel must review all agreements. Requires that charges to clients must not be less than fair market value and cost.

### **REGS.LAB.025 Maintenance of Company Standard Laboratory Chargemaster**

Defines the procedures for updating and maintaining the Company Standard Laboratory Chargemaster and describes the responsibilities of Regulatory Compliance Support and Company-affiliated hospitals.