Summary of Compliance Policies and Procedures Updated FEBRUARY 2019

REGS.GEN.003 Advance Beneficiary Notice of Noncoverage – Outpatient Services

Outlines the use of the mandatory Advance Beneficiary Notice of Noncoverage (ABN) for outpatient hospital services provided to beneficiaries covered by Medicare fee-for-service. ABNs must be obtained in accordance with Medicare requirements. Additionally, hospitals must bill Medicare for all medically necessary services and obtain an ABN for outpatient services that are not medically necessary according to LCD and/or NCD, except as otherwise noted in the policy. Requires using only the CMS-approved ABN form, which may not be altered, a copy of which is attached to the policy.

REGS.GEN.004 Billing - Orders for Hospital Outpatient Tests and Services

Establishes billing guidelines outlining the documentation required for orders for outpatient tests and services in accordance with Medicare, Medicaid and other federally-funded payer guidelines. Orders for hospital outpatient tests and services are valid for billing purposes provided they are documented and include the data elements as defined in the policy.

REGS.GEN.009 Outpatient Services and Medicare Three Day Window

Establishes guidelines for processing, coding and billing Medicare outpatient services provided prior to an inpatient admission in accordance with the Centers for Medicare and Medicaid Services (CMS) regulations.

REGS.GEN.010 Medicare - Hospital Issued Notice of Non-Coverage

Defines the delivery and billing requirements for Hospital Issued Notice of Non-coverage (HINN) for inpatient services not covered by Medicare fee-for-service.

REGS.GEN.011 Medicare - National and Local Coverage Determinations

Defines the requirements for complying with Medicare's National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs). If the requirements within an NCD and/or LCD have not been met, a Hospital Issued Notice of Non-Coverage (HINN) or Advance Beneficiary Notice (ABN) must be issued in order to hold the patient financially responsible for such services. This policy replaced the Medicare – Medical Necessity Policy, REGS.GEN.002, which was retired.

REGS.LAB.006 BILLING – OUTPATIENT SPECIMEN COLLECTION:

When performed by laboratory staff or other facility personnel acting within the scope of their licensure, only one venipuncture, specimen collection via capillary puncture or catheterized urine specimen collection fee will be billed to federally funded programs per outpatient episode of care regardless of the number of specimens obtained. An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility. There will be no charge to federally-funded payers for the collection of specimens when the cost is minimal such as a throat culture or a routine capillary puncture (not for specimen collection)

for clotting or bleeding time. Additionally, specimen collection fees will not be billed when the laboratory test provided does not meet medical necessity guidelines. However, if multiple tests are run from one specimen collected and the other tests are medically necessary, the specimen collection fee may be billed

REGS.LAB.007 Custom Profiles

Outlines 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 hospitals may recognize panels developed by the AMA and adopted for reimbursement by CMS. Hospitals may choose to permit custom profiles provided they are valid, documented, medically necessary, and monitored for appropriateness.

REGS.LAB.009 – BILLING – REFERRED LABORATORY TESTING

To establish guidelines for billing clinical laboratory tests referred to other laboratories in accordance with CMS guidelines.

REGS.LAB.010 Laboratory - Reflex Orders

Establishes guidelines regarding laboratory reflex testing. Laboratory reflex testing must be medically necessary and must be approved by the Medical Executive Committee (MEC) on an annual basis as evidenced in the MEC minutes. Only those reflex tests documented as approved by the MEC may be utilized. Physicians must be informed annually of those tests for which an approved reflex test exists and the implications of ordering such tests. An acknowledgement listing the hospital's active reflex tests must be signed by the physician initially then every two years during the recredentialing process. If the physician does not approve and acknowledge the reflex test listing, a specific order will be required by the physician to order the test..

REGS.LAB.023 Laboratory – Client Billing Practices Policy

Establishes guidelines for the billing and marketing of laboratory services to Clients in an honest, straightforward, informative, compliant and non-deceptive manner. The Laboratory is responsible for verifying that clients fully understand the services offered, the services that will 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 all agreements must be reviewed and approved in advance by the facility's operations counsel. Requires that charges to clients must not be less than fair market value and cost unless the client's account overall yields a profit. Sets forth guidance for determining cost and fair market value.

REGS.LAB.026 BILLING – Hematology Procedures, Urinalysis Procedures, and Organ or Disease-Orientated Panels Policy
Establishes guidance for billing hematology procedures, urinalysis procedures, and organ or disease-oriented panels in accordance with Medicare, Medicaid, and other federally-funded payer requirements.