COMPLIANCE 15.0 BILLING AND CLAIMS REIMBURSEMENT

Scope: All subsidiaries of Universal Health Services, Inc., including facilities, Independence Physician Management, Prominence Health Plan and UHS of Delaware, Inc. and their personnel.

Purpose: To promote full compliance with all relevant federal and state health care program billing and claims reimbursement requirements.

Policy: UHS is committed to compliance with all federal and state health care program requirements for billing and claims reimbursement, including the preparation and submission of accurate claims consistent with such requirements.

Procedure:

1. Adherence to rules, regulations and facility billing policies

All persons involved in health care billing and claims reimbursement activities must know and adhere to all relevant rules and regulations pertaining to federal and state health care program requirements, as well as the applicable facility's billing policies, including but not limited to the following:

- accuracy in all billing activities;
- billing for items actually rendered;
- billing only for medically necessary services;
- billing with correct billing codes;
- preparing accurate cost reports; and
- assuring that no duplicate billing occurs.

2. Overpayments

If a billing error is identified subsequent to the submission of a claim, then steps should be taken to submit the corrected claim. The error should be reported in accordance with the following process:

- For overpayments involving Medicare, Medicaid or any other government payor, the facility will use its best efforts to quantify the overpayment as soon as practicable given the nature of the issue.
- The billing department supervisor shall also immediately report to the Facility Compliance Officer, the Office of General Counsel and the Chief Compliance Officer

of all potential or actual overpayments from Medicare, Medicaid or any other government payors in excess of $25,000.

- The UHS Compliance Office and the UHS Legal Department will assist the facility and any other necessary departments in investigating and reviewing all materials related to the overpayment. If necessary, outside counsel will be consulted to assist in the investigation.

- The use of outside counsel to assist in an investigation requires the authorization of the General Counsel's Office or the Chief Compliance Officer.

- Within 60 days after identification of any overpayment from Medicare, Medicaid or any other government payor, the facility will repay the overpayment unless such overpayment would be subject to reconciliation and/or adjustment pursuant to routine policies and procedures established by the government payor or fiscal intermediary.

- The facility will take remedial steps to correct the problem and prevent the overpayment from recurring.

3. Privacy of Billing and Claims Records

Personnel involved in the billing of claims must not disclose, discuss or otherwise release information regarding patients' condition or treatments, financial, medical, social or other confidential information to unauthorized sources. Billing information is considered protected health information ("PHI") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and is subject to state and federal privacy laws. Personnel involved in the billing process may disclose such information only in connection with the performance of their regular assigned duties in compliance with HIPAA, UHS and facility policies, and other applicable federal and state privacy laws.

Revision Dates:

7-27-2020; 10-12-2017; 10-01-2015; 10-26-2012

Implementation Date: 10-21-2010

Reviewed and Approved by:

UHS Compliance Committee