

## Summary of Policies and Procedures Updated on September 10, 2025

### Communications – See Legal

#### Americans with Disabilities Act (ADA)

##### ADA.001 Access to Services Policy (formerly ADA Accessible Facilities Policy)

Ensures compliance with any applicable public access provisions of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 and Section 1557 of the Patient Protection and Affordable Care Act in HCA Healthcare-affiliated facilities.

##### Accommodating Persons Who are Blind or Have Low Vision Model Policy

This model policy requires development of a plan that accommodates individuals who are blind or have low vision by providing auxiliary aids at no cost to allow them an equal opportunity to participate in and benefit from healthcare services.

##### Accommodating Persons Who are Deaf or Hard-of-Hearing Model Policy

This model policy requires development of a plan that accommodates individuals who are deaf or hard-of-hearing by providing free auxiliary aids in order to ensure equal opportunity to participate in and benefit from healthcare services.

##### Accommodating Persons with Limited English Proficiency (LEP) Model Policy

This model policy requires development of a language access plan that accommodates persons with LEP in order to ensure them meaningful access to participate in and benefit from healthcare services.

##### Accommodating Persons with Service Animals Model Policy

This model policy requires the development of a plan to ensure that persons using service animals have an equal opportunity to participate in and benefit from healthcare services. This model policy specifically differentiates “service animals” from “therapy animals,” and describes the types of animals, as well as sets behavioral guidelines.

##### ADA.002 ADA Compliance – Removal of Physical Barriers Program Policy

The purpose of this policy is to identify and remove physical and accessibility barriers in accordance with the Americans with Disabilities Act (ADA). The policy requires facilities to ensure that their physical plant and buildings are ADA compliant and that all new and renovation construction projects are ADA compliant.

##### ADA.003 External Web Accessibility Policy

The purpose of this policy is to develop a plan that accommodates individuals pursuant to public access provisions of the ADA, Section 504 of the Rehabilitation Act of 1973, Web Content Accessibility Guidelines AA and related statutes, regulations and/or standards by affording persons with disabilities full and equal enjoyment of healthcare and other services obtained by way of accessing the website of an HCA Healthcare-affiliated entity or facility.

### Behavioral Health (BEH)

##### BEH.001 Standards for Confidentiality of Substance Use Disorder Patient Records Policy

Establishes the requirements for HCA Healthcare Affiliate Covered Programs to meet confidentiality standards and utilize patient authorizations to use or disclose Covered Information as required by the Standards for Confidentiality of Substance Use Disorder Patient Records (§42 CFR Part 2).

## **Clinical Operations Group (COG, formerly Quality Management (QM) and Clinical Services Group (CSG))**

### **COG.CMO.002 Screening Tests for Asymptomatic Individuals Policy (formerly CSG.CMO.002)**

Establishes guidelines under which HCA Healthcare-affiliated facilities may promote or endorse screening tests to asymptomatic individuals and to assure to the extent possible that screening tests are supported by high-quality scientific evidence as determined by a national expert review process.

### **COG.COM.001 Core Measure Clarification Process Documentation and Education Policy (formerly QM.COM.001, Core Measure Clarification Process Documentation and Abstraction Education Policy and CSG.COM.001)**

Establishes processes to clarify incomplete or ambiguous documentation that will be used for Core Measures data abstraction. It also defines when a Core Measure query to a provider will be initiated and outlines the appropriate Core Measure query process to be utilized. It is not to be used for questions involving diagnosis or procedure codes as these are covered under REGS.DOC.002.

### **COG.COM.002 Correction of Non-editable Core Measure Data Elements in COMET Policy (formerly QM.COM.002 and CSG.COM.002)**

Defines a standardized process for the correction of non-editable Core Measure data elements in the Clinical Outcome Measures Evaluation and Transmission (COMET) application by facility abstractors. If there is a request for data correction of a Procedure or Diagnosis code, supporting “updated” documentation is required. This requires submission of a scanned coding summary sent to Clinical Analytics.

### **COG.COM.003 Purging of COMET Core Measure Records Policy (formerly QM.COM.003 and CSG.COM.003)**

Defines a standardized process for purging Core Measure records that do not meet the International Classification of Diseases (ICD) population definition for measures in accordance with The Joint Commission Data Quality guidelines. States that Core Measure records can only be purged in accordance with The Joint Commission contractual requirements.

### **COG.COM.004 National Healthcare Safety Network (NHSN) Reporting Policy (formerly CSG.COM.004)**

Provides guidance for responsible parties to submit accurate and timely submission of required data to NHSN by eligible HCA Healthcare Facilities, which will assure compliance with the Center for Medicare and Medicaid Services (CMS) mandated regulatory reporting requirements. Compliance with mandated CMS reporting requirements programs is required to receive the full Annual Payment Update (APU).

### **COG.COM.005 Infection Prevention NHSN Event Documentation Clarification**

Defines processes to clarify incomplete or ambiguous documentation used for abstraction/infection surveillance and provider query process related to public reporting.

### **COG.CQM.001 Purging of eCQM Records within the hCQM Application**

The purpose of this policy is to establish a standardized process to facilitate data purge requests for the hCQM application while ensuring data integrity for internal and regulatory reporting. The policy outlines the entire process including data purge submissions, acceptable and non-acceptable cases for data purge requests, the

supporting information needed to approve these requests, and the responsibilities of entities involved.

COG.FED.001 Investigator Conflicts of Interest in PHS Grants Policy (formerly CSG.FED.001)  
Establishes that the Institution shall identify and manage any Investigator's Financial Conflicts of Interest related to Public Health Service (PHS) funded research in accordance with PHS regulations.

COG.FED.002 Research Misconduct in PHS Grants Policy (formerly CSG.FED.002)  
Establishes that the Institution has the responsibility to follow all procedures set forth in this policy to ensure compliance with federal regulations §42 CFR parts 50 and 93 when conducting Public Health Service (PHS)-funded studies.

COG.FED.003 Compliance with Federal Funding Accountability and Transparency Act ("FFATA") Policy (formerly CSG.FED.003)  
The purpose of this policy is to provide the Federal Government with information necessary for their transparency to the general public on government spending. This policy does not address any State or other reporting requirements.

COG.IAC.001 Institutional Animal Care and Use Committees Policy (formerly CSG.IAC.001)  
**RETIRED**  
This policy was **retired** on May 24, 2022.

COG.IRB.001 IRB Related Definitions and Common Acronyms Policy (formerly CSG.IRB.001)  
Provides consistent definitions of key terms (either specifically defined by or consistent with regulations) used across all IRB compliance policies in a single location for easy reference. The abbreviations and definitions in this policy are for use in the Institutional Review Board policies, COG.IRB.001 through COG.IRB.011.

COG.IRB.002 IRB Membership and Training Policy (formerly CSG.IRB.002)  
Provides guidance for adequate representation for proper IRB decision-making. The policy states that each IRB run by the facility must be appropriately constituted according to federal law. The policy provides guidance regarding appointment, evaluation and removal of IRB members, and training of IRB members.

COG.IRB.003 IRB Registration with, and Mandated Reports to, FDA and/or DHHS Policy (formerly IRB Registration with, and Mandated Reports to DHHS Policy; and CSG.IRB.003)  
Provides guidance to Internal IRB's on the appropriate registration and reporting to/with the United States Government in accordance with federal law. This policy provides guidance on the procedure for registering IRB's and the required reporting.

COG.IRB.004 IRB Records (Rosters, Minutes and Protocol Information) Content and Retention Policy (formerly CSG.IRB.004)  
Provides guidance on the proper documentation of IRB activity for validation and audits. The policy provides guidance regarding IRB roster and member information, meeting minutes, protocol records, and record retention.

**COG.IRB.005 IRB Development of Local Standard Operating Procedures Policy (formerly CSG.IRB.005)**

Provides guidance for developing Standard Operating Procedures (SOP) required by regulation for the IRB oversight of non-exempt human subject research. Federal regulations require each IRB to develop and follow local written procedures that address, at a minimum, the topics outlined in this policy.

**COG.IRB.006 IRB Criteria to Approve or Exempt Human Subject Research Policy (formerly CSG.IRB.006)**

Provides guidance for IRB's to either exempt or approve human subject research. The policy provides guidance regarding IRB exempt determinations and criteria to approve research.

**COG.IRB.007 IRB Initial and Continuing Review of Non-Exempt Research with Human Subjects Policy (formerly CSG.IRB.007)**

Provides guidance on a systematic review of non-exempt human subject research activities that supports the protection of human subjects and is compliant with state and federal regulations. The IRB must review all its assigned non-exempt research involving human subjects as defined in CSG.IRB.001. The IRB must assess whether its members have the knowledge, skill and experience to adequately review and approve the submitted research and secure adequate consultation if they do not or refer the protocol to a properly experienced IRB.

**COG.IRB.008 IRB Review of Research Informed Consent and Its Documentation Policy (formerly CSG.IRB.008)**

Provides guidance and structure to the IRB in its review of the need for required structure and elements of informed consent and the need for documentation of consent as well as the criteria to waive either of the above for certain circumstances.

**COG.IRB.009 IRB Required Additional Protections for Vulnerable Subjects/Children Policy (formerly CSG.IRB.009)**

Provides guidance for IRB's regarding protecting the welfare of particularly vulnerable subjects, such as children, prisoners, pregnant women, or other persons deemed by the IRB as needing additional protections. The IRB must ensure that it has adequate representation on the Board to consider specific kinds of research involving these vulnerable populations in a satisfactory manner. IRB's must review the regulations referenced in the reference section of this policy to understand the requirements pertaining to potentially vulnerable subject populations.

**COG.IRB.010 IRB Handling Conflicts of Interest in Research Policy (formerly CSG.IRB.010)**

Provides guidance on how to assure protection of human subjects in the presence of potential conflicts of interest with investigators or IRB members. The policy provides guidance regarding identifying potential conflicts of interest, determining a potential conflict of interest as affecting human subject protection, and eliminating or managing conflicts of interest potentially affecting human subject protection.

**COG.IRB.011 IRB Review and Reporting of Unanticipated Problems Involving Risks to Subjects or Others Policy (formerly CSG.IRB.011)**

Provides guidance regarding the IRB's review of meaningful new events that affect human subject protection and provides all required internal, external and governmental

reporting of these events. The events the IRB must review are not routine and require prompt review and reporting, sometimes to federal regulators.

**COG.MM.001 Controlled Substance Monitoring Policy (formerly QM.003, CSG.MM.001 & CSG.MM.003)**

Establishes controls related to ordering, receiving, prescribing, dispensing, administering, documenting, and handling controlled substances. The policy also promotes patient safety, while defining monitoring processes that provide early detection of medication control irregularities. Follows federal and state controlled substance laws and regulations in addition to any applicable HCA Healthcare policies and procedures.

**COG.MM.004 Pharmacy and Laboratory-Related Dependent Healthcare Professionals Policy (formerly CSG.MM.004)**

Defines pharmacy and laboratory-related Dependent Healthcare Professionals (DHPs) access to, and interactions with, the Company and its colleagues.

**COG.MM.006 DEA and State Controlled Substance Diversion and Loss Reporting Policy (formerly CSG.MM.006)**

Requires appropriate reporting to the U.S. Drug Enforcement Administration (DEA) and State Agencies of any Theft or Significant Loss of a Controlled Substance.

**COG.PPA.001 Sharing Credentialing, Privileging, and PPE Information among HCA Healthcare Entities Policy (formerly CSG.PPA.001)**

Provides that information sharing is an essential and integral part of the credentialing, privileging, and professional practice evaluation/peer review activities of HCA Healthcare Entities. It promotes timely and informed determinations regarding Practitioners in furtherance of two primary objectives: (i) ensuring patient safety and the quality of care provided to patients; and (ii) fostering a culture of continuous improvement for Practitioners.

**COG.PPA.002 Licensure and Certification Policy (formerly QM.002, CSG.QS.002 & CSG.PPA.002)**

Ensures licensed independent practitioners and advance practice professionals who provide patient care and/or order patient care services in a Company-affiliated facility have required licensure, are not ineligible persons, possess a valid National Provider Identifier (NPI), are not excluded from participation in an applicable state healthcare program and have current clinical privileges for the patient care being rendered when required.

**COG.PPA.003 Vetting Dependent Healthcare Professionals and Other Non-Employees Policy (formerly CSG.QS.003 & CSG.PPA.003)**

Designed to ensure that access and provision of patient care services to Company-affiliated facilities is provided by DHPs who are qualified, competent, oriented to the facility setting, appropriately supervised, and periodically evaluated in their provision of safe, effective, efficient and appropriate care, treatment or services, and to assure that access to any safety- or security-sensitive areas of a Company-affiliated facility is granted only to authorized non-employees.

COG.PUB.001 Designation as Authors and Contributors in Scholarly Work Policy

Provides a consistent criterion, based on international standards, for designation of “Author” and “Contributor” in the publication of scholarly work. It also describes the process for handling disputes in this area.

COG.PUB.002 Publication of Clinical Evidence Approval Review (“PubCLEAR”) Policy

Lays out the requirement for CSG clearance of clinical-related publications authored by members of the company workforce.

COG.PUB.003 Responsible Use of Generative Artificial Intelligence in Scholarly Work Policy

Lays out the responsibilities and accountabilities of the Author(s) when they, their co-authors or their contributors use Generative Artificial Intelligence (Gen AI) assistive technologies in the creation of their scholarly work. It requires, among other thing, compliance with the company’s Responsible AI requirements, the obligations of identification of the non-human generated content, disclosure of the use of the Gen AI tools and accountability of the author(s) of the final workproduct.

COG.RAS.001 Regulatory Compliance Notification Policy (formerly QM.001, CSG.QS.001 & CSG.RAS.001)

Ensures that each Company-affiliated facility and subsidiary provides immediate notification to Corporate and Division management:

- of any surveys by any third-party agency for any reason at their facility;
- upon receipt of any request for copies of patient or facility records for use in an investigation of an alleged compliance violation;
- upon receipt of written communication from the facility’s Quality Improvement Organization (QIO) or other health care survey or enforcement agency pertaining to a formal project that will involve aggregate reporting of data or information to the QIO or requesting agency; and
- upon identification by the facility of the obligation to notify a regulatory/accrediting body of an adverse event or violation of a state/federal regulation via self-reporting communication to the applicable body.

COG.RAS.004 Patient Rights Policy (formerly CSG.QS.004 & CSG.RAS.004)

Designed to ensure that there is no harassment, discrimination or distinction in the availability of services; the admission, transfer or discharge of patients; or in the care provided. It also requires facilities to inform patients of their patient rights and responsibilities and visitation rights. Requires facilities to adopt, use and post the model statements of patient and visitation rights.

COG.RAS.005 COVID-19 Vaccination Requirements for Employees and Staff of HCA CMS Mandate Facilities Policy **RETIRED**

This policy was retired on August 4, 2023.

COG.RAS.006 Controlled Substance State Licensing and DEA Registration Policy

Defines the requirements related to controlled substance handling. Before engaging in any activities related to controlled substances (including but not limited to, ordering, receiving, storing, dispensing, administering, or transferring), a facility must be properly licensed under applicable state and federal laws. Proper licensure includes (1) an Institutional Practitioner (Hospital/Clinic) DEA Registration and (2) any applicable state licenses (including, if applicable, controlled substance permits).

COG.RSH.001 Research - Guiding Documents and Definitions Policy (formerly CSG.RSH.001)  
Provides the facility with a quick reference to the appropriate federal and local laws pertaining to clinical research as well as appropriate guidance. The policy provides consistent definitions of key terms (either specifically defined by, or consistent with, regulations) used across all research compliance policies in a single location for easy reference.

COG.RSH.002 Research Integration into Healthcare Treatment/Payment/Operations Policy (formerly CSG.RSH.002)  
Pertains to the oversight of integrating the complexities of research operations into the complexities of healthcare delivery operations. It is not to be confused with the IRB review of research or a compliance manual for the conduct of research itself. The facility shall establish a research integration oversight infrastructure customized to the needs of the facility. There are no regulations or specific instructions directly governing this infrastructure; however, common themes are included in the policy.

COG.RSH.003 Human Subject Protection Program Policy (formerly CSG.RSH.003)  
Applies to all research with human subjects in which colleagues of a Company-affiliated facility become engaged. The policy provides guidance on protecting the rights and well-being of human subjects in clinical research. The facility shall have a human subject protection infrastructure that oversees research with human subjects. Such a program contains the minimum designations outlined in the policy.

COG.RSH.004 Use of and Relationship with Institutional Review Boards Policy (formerly CSG.RSH.004)  
Concerns the facility's use of IRB's that can be internal or external. This policy provides guidance on the facility's delineation of the requirements to certify IRB review by either running an internal IRB and/or deferring to external IRB's. The policy describes how the IRB should function independently of facility administration decisions regardless of whether it is internal or external. The policy also provides guidance on the facility's written requirements (not the IRB's requirements) for use of one or more IRB's. Finally, it provides guidance on the process needed to assure that the facility does not become engaged in non-exempt human subject research activity unless that research activity is under the oversight of an IRB.

COG.RSH.005 Research Activities Not Needing IRB Oversight or Certification of IRB Review Policy (formerly CSG.RSH.005)  
Provides guidance for certain kinds of research, in which federal regulations allow the Institutional Official to certify that research activity undertaken by the institution does not need (internal or external) IRB oversight, or although it needs IRB oversight, the institution does not need to certify that IRB oversight occurred. The Institutional Official or their designee may determine that certain research does not need oversight by an IRB; however, the Institutional Official may not overrule a previous decision by an IRB. The policy provides a decision tree to use to determine if research activity needs IRB oversight.

COG.RSH.006 Handling Research Informed Consent Documents (Non-IRB Requirements) Policy (formerly CSG.RSH.006)  
Provides guidance regarding documenting consent to participate in research (and the content of such consent process), which is usually communication isolated between the

researchers, the IRB and the subjects. However, the documentation of such consent is often relevant to healthcare operations. This occurs, among other circumstances, when standard of care must be deviated from for research purposes (thus increasing risk to the subject) and/or for justifying recusal from their case being counted in reported statistics as should have been receiving evidence-based care.

**COG.RSH.007 Special Cases Concerning Investigational Products and Humanitarian Use Devices Policy (formerly CSG.RSH.007)**

Provides guidance in the following:

1. In rare instances, a facility is faced with a clinical emergency where the treating physician desires to use test article (i.e., an investigational drug, device or biologic) outside of the protocol it is used in. Although these products are not available for commercial use outside of clinical trials, there are legal criteria that the treating physician can testify to in writing to allow the use in the emergency outside of IRB-approved protocols.
2. When a facility accepts the admission of a clinical research subject for medical care not as a result of research participation (i.e., a “second institution”), it may need to continue the investigational drug or device (or provide other services such as protocol driven safety evaluations) during the patient/human research subject’s admission to the hospital (as a patient) if deemed appropriate by the Admitting Physician in consultation with the Principal Investigator.
3. Although Humanitarian Use Devices (HUDs) and products available under the FDA’s Expanded Access Program (EAP Products) are approved for treatment use by the FDA, their use requires IRB approval and oversight by the facility according to FDA law, unless waived by the FDA.

**COG.RSH.008 Access to Records for Research or Research Monitoring Purposes (Non-IRB Requirements) Policy (formerly CSG.RSH.008)**

Provides guidance regarding balancing the rights to individual privacy with the rights of researchers to access private information. Researchers must adhere to the federal and local privacy laws and be consistent with any individual authorizations.

**COG.RSH.009 Role of Institutional Official and Human Protections Administrator Policy (formerly CSG.RSH.009)**

Describes two key oversight roles that a facility has when overseeing clinical research. If the facility is engaged in clinical research (including exempt and non-exempt research with human subjects), they shall define which person or persons fills the roles of Institutional Official and Human Protection Administrator (one person can fulfill both roles). The policy provides guidance on the roles of Institutional Official and Human Protections Administrator.

**COG.RSH.010 Research Activity Records and Reports Policy (formerly CSG.RSH.010)**

Provides guidance regarding the information that should be maintained by the facility in its support of research. Proper maintenance of these items will be of great assistance in regulatory and accreditation surveys as well as internal and external audits.

**CSG.CA.001 Excluding Patients from the Patient Survey Process Policy**

See PE.CA.001, as of 1/1/2018.



CSG.MM.002 Substance Use in the Workplace Policy (formerly Drug Free Workplace Policy, HR.OP.008)

See HR.ER.060, as of 11/1/2017.

CSG.RES.001 IRB Guidance Policy (formerly QM.IRB.001 and QM.RES.001) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.002 IRB Protocol Initial and Continuing Review Policy (formerly QM.IRB.002 and QM.RES.002) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.003 Informed Consent IRB Review Policy (formerly QM.IRB.003 and QM.RES.003) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.004 Development of Local Standard Operating Procedures for IRB Policy (formerly QM.IRB.004 and QM.RES.004) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.005 Adverse Event and Unanticipated Problems in Research Review Policy (formerly QM.IRB.005 and QM.RES.005) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.006 Use of Non-Local, Cooperative and Multi-Institutional IRB's Policy (formerly QM.IRB.006 and QM.RES.006) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.007 Recruitment of Vulnerable Subject Populations Policy (formerly QM.IRB.007 and QM.RES.007) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.008 Handling Conflicts of Interest in Research Policy (formerly IRB Guidance – Conflict of Interest Policy, QM.RES.008) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.009 Use of Investigational Products When Subjects Enter a Second Institution Policy (formerly QM.RES.009) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.010 Humanitarian Use Device and Humanitarian Device Exemption Policy (formerly QM.RES.010) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.011 Responsible Conduct of Research within the Facility Policy (formerly QM.RES.011) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.012 Pediatric Research Policy (formerly Pediatric Assent Policy, QM.RES.012) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

CSG.RES.013 IRB Registration Policy (formerly QM.RES.013) **RETIRED**

On November 1, 2011, this policy was approved for retirement effective March 1, 2012.

**Design and Construction (DC) – (formerly Capital Deployment - Construction and Equipment (CD.CE))**

DC.001 Plant Operations – Procuring Design and Construction Services for Hospital Managed Project Policy (formerly DC.020, CD.CE.020)

Establishes processes and controls for procuring design and construction services for facility-managed projects.

**Emergency Operations Group – Security Services (EOG.SS) (formerly Information Protection and Security – Physical Security (IP.PS))**

EOG.SS.001 Physical Security Management Plan Policy (formerly IP.PS.001)

Lays the groundwork for facilities to identify how they manage the overall security of their patients, colleagues, visitors and property.

EOG.SS.002 Workplace Violence Prevention Policy (formerly IP.PS.002, IP.PS.006 & SS.001)

This policy lays out the must haves that hospitals should have incorporated into the development of their Workplace Violence Prevention Plans.

EOG.SS.003 Active Shooter Hostile Event Response (ASHER) Policy (formerly IP.PS.003)

Establishes a framework for Company facilities to prepare for, mitigate risk of, respond to and recover from an active shooter hostile event (ASHER). In the event an individual(s) enters the facility displaying a firearm as an active shooter hostile event, workforce members should determine the most reasonable way to protect their own lives.

EOG.SS.004 Chain of Custody – Illegal Items/Substances Policy (formerly IP.PS.004)

Establishes guidelines for facility workforce to use in the collection and preservation of illegal items/substances found/acquired upon search on facility property. This policy establishes a framework for the receipt, secure storage, audit, release and disposition of illegal items and substances discovered within the facility.

EOG.SS.005 Infant Security Program Policy (formerly IP.PS.005)

Addresses the overall security program requirements for hospitals that provide perinatal and neonatal services.

EOG.SS.007 Pediatric Security Program Policy (formerly IP.PS.007)

Addresses the overall security program requirements for hospitals that provide pediatric care and services.

EOG.SS.008 Search and Seizure Policy (formerly IP.PS.008)

This policy outlines criteria and procedures for conducting search and seizure on Company property in order to provide, as reasonably as possible, a safe environment for individuals within the facility. The policy also describes procedures to follow for discovery of a weapon, item or other property, required documentation and workforce training.

EOG.SS.009 Use of Force Policy (formerly IP.PS.009)

This policy provides a framework around the reasonable use of force applied during situations of subjects actively exhibiting verbal resistance or physical violence.

EOG.SS.010 Forensic Patient Management Policy (formerly IP.PS.010)

This policy provides a framework to ensure that forensic patients in the custody of law enforcement officials are in a safe and secure environment, and the appropriate measures are taken to ensure the safety of patients, visitors and colleagues.

EOG.SS.011 Conducted Energy Device (CED) Policy (formerly IP.PS.011)

This policy provides security personnel direction for the use of Conducted Electrical Device (CED), which intends to control a violent subject exhibiting active aggression, while aiming to minimize the risk of serious injury.

## **Environmental (ENV)**

ENV.001 Environmental and Waste Management Policy (formerly DC.001)

Describes the policy framework for environmental compliance and provides the plan template for facilities to develop a specific Environmental and Waste Management Plan.

ENV.002 Environmental – Polychlorinated Biphenyls (PCBs) Handling Policy (formerly DC.002)

**RETIRED**

This policy was **retired** on November 16, 2010.

ENV.003 Environmental – Indoor Air Quality Policy (formerly DC.003)

Requires each facility: provide a safe indoor environment for patients, colleagues and the public by properly maintaining the ventilation and associated systems; and maintain all ventilation equipment in proper operating condition and be certain that prescribed ventilation rates are adequate to keep the concentration of harmful chemicals, fumes, or odors below the limits for air contaminants set by the *NOISH Pocket Guide (NPG)*.

ENV.004 Environmental – Air Pollution Emission and Control Policy (formerly DC.004)

**RETIRED**

This policy was **retired** on November 16, 2010.

ENV.005 Environmental – Asbestos Containing Material (ACM) Management Policy (formerly DC.005) **RETIRED**

This policy was **retired** on November 16, 2010.

ENV.006 Environmental – Environmental Due Diligence for Property Transfer Policy (formerly DC.006)

Establishes a process for performing environmental due diligence prior to property transfers or leases. Requires a Phase I Environmental Site Assessment (ESA) be performed during the due diligence process. Such ESA must conform to the *Standard Practice for Environmental Site Assessments: Phase I Environmental Site Assessment Process* as specified under the American Society of Testing and Materials and the EPA's "Standards and Practices for All Appropriate Inquiries."

ENV.007 Environmental – Emergency Response Policy (formerly DC.007) **RETIRED**

This policy was **retired** on November 16, 2010.

ENV.008 Environmental – Biomedical Waste Management Policy (formerly DC.008) **RETIRED**  
This policy was **retired** on November 16, 2010.

ENV.009 Environmental – Low-Level Radioactive Waste Management Policy (formerly DC.009) **RETIRED**  
This policy was **retired** on November 16, 2010.

ENV.010 Environmental – Hazardous Waste Management Policy (formerly DC.010) **RETIRED**  
This policy was **retired** on November 16, 2010.

ENV.011 Environmental – Fuel Storage Tank Management Policy (formerly DC.011) **RETIRED**  
This policy was **retired** on November 16, 2010.

ENV.012 Environmental – Waste Oil Management Policy (formerly DC.012) **RETIRED**  
This policy was **retired** on November 16, 2010.

ENV.013 Environmental – Wastewater Discharge Policy (formerly DC.013) **RETIRED**  
This policy was **retired** on November 16, 2010.

ENV.014 Environmental – Potable (Drinking) Water Supply Policy (formerly DC.014) **RETIRED**  
This policy was **retired** on November 16, 2010.

ENV.015 Environmental – Infection Control Risk Assessment Policy (formerly DC.015) **RETIRED**  
This policy was **retired** on November 16, 2010.

ENV.016 Environmental – Universal Waste Management Policy (formerly DC.016) **RETIRED**  
This policy was **retired** on November 16, 2010.

ENV.017 Environmental – Lead Management Policy (formerly DC.017) **RETIRED**  
This policy was **retired** on November 16, 2010.

ENV.018 Environmental – Self-audit of Facilities Policy (formerly DC.018) **RETIRED**  
This policy was **retired** on November 16, 2010.

ENV.019 Energy Efficiency Improvement Policy **RETIRED**  
This policy was **retired** on May 24, 2022.

ENV.020 Mercury Reduction and Virtual Elimination Policy  
Establishes the Company's commitment of reducing and seeking to achieve virtual elimination of mercury in the most efficient, cost effective and environmentally responsible manner while providing a healthy environment for its patients, providers, colleagues and visitors and to continue its commitment to the care and improvement of human health.

ENV.021 Hospital Reporting on Mercury Reduction and Virtual Elimination Policy  
Provides a process for hospitals to document efforts of reducing and seeking to achieve virtual elimination of mercury and mercury-containing devices in accordance with the Mercury Reduction and Virtual Elimination Policy, ENV.020.

## **Ethics and Compliance (EC)**

EC.001 Policy and Procedure Development Policy

Establishes protocols for the development, revision, editing, and implementation of policies and procedures for areas that: 1) Pose risks for non-compliance with laws and regulations, and 2) Promote compliance with the Code of Conduct. Requires approval of such policies by the Corporate Ethics and Compliance Policy Committee. Provides guidance detailing the procedures facilities should use as they receive policies and procedures.

EC.002 Internal Handling of Ethics Line Calls Policy

Establishes internal protocols for the handling of Ethics Line reports and investigations. The Ethics Line receives ethics or compliance related concerns via telephone calls and/or written submissions to the third party administrator of the call center, HCA Healthcare Ethics and Compliance, HCA Healthcare Ethics Line Internet portal, HCA Healthcare websites or other Corporate Departments. Ethics Line cases will be handled in a manner that preserves confidentiality of the reporter and individuals involved in the investigation. Reports are investigated and closed within 30 days of receipt, in most cases, by persons having a sufficient level of expertise or knowledge with regard to the issue(s) presented; and include disciplinary or corrective action, when allegations are substantiated.

EC.003 Self-Reporting of Violations of Certain Laws and Regulations Policy **RETIRED**

This policy was **retired** on May 17, 2011.

EC.004 Code of Conduct Policy (formerly Effective Date of Code of Conduct Policy)

Establishes the effective date of the Code of Conduct and requires an annual consideration of possible revisions to the Code of Conduct.

EC.005 Business Courtesies to Potential Referral Sources Policy

Establishes parameters for the extension of business courtesies to potential referral sources, who are not Foreign Officials, and their immediate family members. To establish parameters for the receipt by Facilities of business courtesies from potential referral sources or referral recipients, or their immediate family members.

EC.006 Entertainment Policy

Establishes application rules related to business courtesies involving individuals and entities that **are not** potential referral sources or Foreign Officials. Specifically, provides that invitations of entertainment extended, using Company funds, to current or potential business associates should not exceed a cost of \$150 per person nor occur more than three times a year. Similarly provides that invitations to attend or participate in social events received from colleagues or business associates may be accepted provided that the value does not exceed \$150 per person. Provides guidance regarding limits as to what Federal employees are allowed to accept and limits as to what Company colleagues are allowed to provide to Federal employees.

EC.007 Business Associate-Sponsored Meetings, Trainings and Honoraria Policy (formerly Vendor-Promotional Training, Business Associate-Sponsored Seminars and Honoraria)

Establishes the parameters surrounding acceptance of business associate-sponsored meetings and training and establishes honoraria guidance. Business associates may not pay any substantive portion of travel expense related to pre-purchase product evaluation. Other offers for training and meetings, including travel and lodging, may be

accepted free of charge when the business value to our organization outweighs any recreational or entertainment value of the event, provided that the appropriate approvals are obtained in advance. Prohibits the acceptance of honoraria when individuals are invited to speak at conferences or seminars on behalf of the Company.

**EC.008 Approval of Tokens of Appreciation in Recognition of Volunteer Efforts from Non-Referral Sources Policy**

Establishes the approval and exception process for tokens of appreciation to non-referral sources in recognition of their volunteer efforts on behalf of the Company. Requires there be a reasonable relationship between the time and effort extended by the volunteer and the value of the gift.

**EC.009 Reimbursement of Expenses Related to Voluntary Leadership Service by Physicians Policy **RETIRED****

This policy was **retired** effective March 15, 2005. This policy has been replaced by the Reimbursement of Expenses and Extending Tokens Related to Voluntary Leadership Service by Potential Referral Sources Policy, LL.022.

**EC.010 Ethics and Compliance Officer Policy**

Establishes that each facility have an Ethics and Compliance Officer (ECO) and requires each hospital to establish a Facility Ethics and Compliance Committee (FECC). The ECO must oversee and implement the Ethics and Compliance Program and the facility's compliance with the requirements of Federal health care programs.

**EC.011 Code of Conduct Distribution and Training Policy**

Establishes requirements for distributing the Company's Code of Conduct ("Code"), collecting Code acknowledgments, and conducting orientation and refresher Code training for Company colleagues and Qualifying Individuals. Requires reporting and an action plan when individuals do not complete training in the designated time frame. The policy requires that Code Orientation and Refresher training be tracked using the Company's HealthStream Learning Center (HLC).

**EC.012 Correction of Errors Related to Federal Healthcare Program Reimbursement Policy **RETIRED****

This policy was **retired** effective January 24, 2009.

**EC.013 Physician Access to the Internet Policy **RETIRED****

This policy was **retired** effective January 1, 2006. The Physician Access to the Internet Policy, LL.026, includes guidance previously in this policy.

**EC.014 Records Management Policy**

Governs the creation, use, maintenance, retention, preservation, and disposal of Company records. All records generated and received by the Company are the property of the Company and no Company employee has any personal or property right to such records even though he or she may have developed or compiled them. Prohibits the unauthorized destruction, removal or use of such records and falsifying or inappropriately altering information in any record or document. A link to minimum records retention schedules on Atlas Connect is provided in the policy.

EC.015 Limitations on Gifts to Fiscal Intermediary Employees Policy

Extends the restrictions in the Code of Conduct regarding gifts to Federal employees or employees of fiscal intermediaries. Gifts to fiscal intermediary or carrier employees are limited to modest refreshments provided in the course of a business meeting.

EC.016 Ethics and Compliance Program Contracts Policy

Ensures that all vendor contracts that relate in any way to the Ethics and Compliance Program include language prohibiting such vendors from using their relationship with the Company in a public way without prior written approval.

EC.017 Notification Regarding Certain Investigations or Legal Proceedings Policy **RETIRED**

This policy was **retired** effective January 24, 2009. The requirements previously in this policy are now within the Reporting Compliance Issues and Occurrences to the Corporate Office Policy, EC.025.

EC.018 ECO Quarterly Reports Policy **RETIRED**

This policy was **retired** effective February 1, 2009.

EC.019 CIA Training for Senior Management Policy **RETIRED**

This policy was **retired** effective December 31, 2008.

EC.020 Reportable Events Policy **RETIRED**

This policy was **retired** effective January 24, 2009. The requirements previously in this policy are now within the Reporting Compliance Issues and Occurrences to the Corporate Office Policy, EC.025.

EC.021 Conflict of Interest Policy

Enables affected individuals to understand, identify, manage and appropriately disclose actual, potential or perceived conflicts of interest. Requires that affected individuals review the policy at least annually and complete a Conflict of Interest Certification within 90 days of becoming an affected individual.

EC.022 Adoption, Surrogacy and Infant Relinquishment Policy (formerly Adoption and Surrogacy Policy)

Establishes guidelines to protect the interests of all who are involved in the adoption or surrogacy birth of an infant delivered in a Company-affiliated facility including preventing undue or inappropriate influence on birthparents considering adoption; requiring a facility-specific policy be adopted to address such issues as infant adoptions, the birth of a child delivered by a surrogate or an infant who has been left at a hospital under a safe-haven law situation.

EC.023 Gifts Policy

Establishes parameters for the extension of gifts to, and the receipt of gifts from, individuals or organizations who have a business relationship with the Company but which are not Foreign Officials. Gifts **received from** potential referral sources and potential referral recipients are governed by this policy. Gifts **given to** individuals who are potential referral sources and their immediate family members are governed by the Business Courtesies to Potential Referral Sources Policy, EC.005. Provides that Company colleagues may give or accept gifts with a total value of \$75 or less in any one year to or from an individual or organization who has a business relationship with the

Company.

**EC.024 Potential Identity Theft Indicators Policy**

Establishes a company-wide policy to address the risk associated with a patient, patient's representative, or another party presenting false identifying or insurance information for the purpose of obtaining services. Requires all facilities to be familiar with the Identity Theft Indicators set forth in the policy.

**EC.025 Reporting Compliance Issues and Occurrences to the Corporate Office Policy**

Requires certain events, occurrences or issues ("Events"), which are described more fully in the policy must be reported to the appropriate Corporate Departments, as identified in the policy, immediately and in no event later than three (3) business days after discovery.

**EC.026 Appropriate Use of Communications Resources and Systems Policy (formerly Appropriate Use of Company Communications Resources and Systems Policy)**

Sets the parameters for the use of communication resources, particularly electronic resources, such as email, Internet services and digital media. Provides guidance that colleagues must not use external email systems to conduct Company business. Instructs users to presume no expectation of privacy in anything they may access, create, store, send or receive on Company computer systems. Also provides guidance on the use of digital media and the content of all communications, which should be truthful and accurate, sent to recipients based on a need-to-know and sent or posted with appropriate security measures applied in accordance with the Information Security Standards.

**EC.027 Publication Conflicts of Interest Disclosures Policy**

Provides financial disclosure guidance for when Covered Physicians Publish in a Medical Journal or Present at a Medical Conference. Such Covered Physicians are expected to disclose their financial relationships in accordance with applicable laws, regulations, rules, policies and procedures related to such disclosure ("Disclosure Rules"). The policy provides examples of Disclosure Rules.

**EC.028 Vendor Relations Policy (formerly MM.002)**

Articulates expectations of the Company and its colleagues in their interactions with Vendors and establishes parameters for seeking and accepting funds from Vendors for company meetings, educational programs, community health events, company-sponsored marketing activities and charitable functions.

**EC.029 Professional Educational Funding from Vendors Policy (formerly Educational Funding from Vendors Policy, MM.004)**

Clarifies circumstances where educational funding may be accepted from vendors and requires the approval of a Division ECO or VP, Ethics and Compliance. Prohibits acceptance of vendor funding for any meeting where residents would be participants. Prohibits company colleagues from contributing in-kind services to vendors for a vendor's independent meetings. Removes detailed accounting requirements for such funding.



EC.030 Non-Retaliation Policy

Establishes guidance for reporting ethics or compliance concerns or other wrongdoing and provide protection against retaliation for employees who report in good faith an ethics or compliance related concern or other wrongdoing.

EC.031 Responsible AI Policy

Ensures the responsible development, deployment, and use of Artificial Intelligence (AI) across the Company following the pillars of the Responsible AI Framework. Responsible AI includes respecting individuals' privacy, promoting transparency, fairness, bias minimization, accountability, and operation in a safe and secure manner that strives to protect individuals from physical, emotional, environmental, and/or digital harm.

**Governmental Operations Support**

See Regulatory Compliance Support (REGS) for former GOS policies.

**Government Relations (GR)**

GR.001 Political Contributions Policy

Provides guidance to Corporate and facility management concerning political contributions (personal and Corporate) to candidates and political action committees (PACs) at the local, state, and federal levels. The decision as to whether or not to contribute is at the sole discretion of the individual and any decision not to participate shall have no impact on any personnel actions regarding such individual.

GR.002 General Statement on Government Relations Policy

Provides guidance regarding the Company's participation in public policy matters and interaction with government officials. Requires the Company to fully disclose its involvement with any trade association, and to not coerce colleagues to participate in any lobbying effort or to participate in any PAC or political activity on its behalf.

**Graduate Medical Education (GME)**

GME.001 GME – Use of Institutional and Personal DEA Registration Numbers Policy

Provides guidance regarding Resident prescribing of controlled substances. Specifically, to address the correct use by Residents of a facility's Institutional DEA Registration Number while the Resident is providing care in HCA Healthcare facilities.

**Health Information Management Services**

See Regulatory Compliance Support (REGS.COD) for Coding policies and (REGS.OSG) for Outpatient Services Group (formerly HIM.PHY) policies.

**Health Information Management: Privacy**

See Information Protection – Patient Privacy (IP.PRI) for former HIM.PRI policies.

**Human Resources (HR) Model Policies**

HR.ER.002 Background Investigations Policy (formerly HR.OP.002 and HR.102)

Provides a standard requirement and process for obtaining and evaluating background information on Subjects, as defined in the policy. Addresses candidates moving from one affiliated facility to another and individuals hired through a temporary agency or contract, and third party and Company affiliate ownership of the background investigation report.

HR.ER.013 Equal Employment Opportunity Policy (formerly HR.OP.014 and HR.201) **RETIRED**  
This policy is **retired** effective December 31, 2021. This policy has been replaced by the Equal Employment Opportunity, Anti-Harassment and Respectful Workplace Policy, HR.ER.072.

HR.ER.013.FWD.CA Equal Employment Opportunity (Model Policy for California)  
Ensures all colleagues and customers are treated in accordance with HCA Healthcare's mission and values while ensuring compliance with federal, state and local equal employment opportunity regulations and statutes (facility name/logo to be added to header).

HR.ER.019 Limitations on Employment Policy (formerly HR.OP.019 and HR.209)  
Defines the legal or ethical limitations that may exist in establishing an employment relationship with an individual and the responsibility of the Affiliated Employer to recognize these issues in the hiring process. Specifically addresses: hiring former fiscal intermediary personnel; not hiring ineligible persons; employment of minors; employment of relatives; the use of contract personnel; and the use of Verity.

HR.ER.022 Reference Inquiry and Wage Verification Policy (formerly Reference Inquiries, HR.OP.028 and HR.205) **RETIRED**  
This policy is **retired** effective December 31, 2021. This policy has been replaced by the Equal Employment Opportunity, Anti-Harassment and Respectful Workplace Policy, HR.ER.072.

HR.ER.024 Sexual Harassment Policy (formerly Respectful Workplace, HR.OP.014 and HR.201)  
This policy is **retired** effective December 31, 2021. This policy has been replaced by the Equal Employment Opportunity, Anti-Harassment and Respectful Workplace Policy, HR.ER.072.

HR.ER.060 Substance Use in the Workplace Policy (formerly CSG.MM.002 and formerly Drug Free Workplace Policy, HR.OP.008)  
Prohibits inappropriate drug or alcohol use by our colleagues and students in the workplace so as to ensure the quality of care we provide to patients, the safety of our workplace and a healthy work experience. Establishes the framework for conducting drug testing.

HR.ER.071 Title IX Sexual Misconduct Policy  
This policy applies to allegations of Title IX Sexual Misconduct of the Education Amendments of 1972 against individuals employed by an HCA Healthcare-affiliated GME Program (hereinafter, interchangeably referred to as "Employer" or "Program") as a faculty member, Program Coordinator, Resident, or Fellow of that program, regardless of where the alleged conduct occurred. Third parties (e.g., contractors, applicants for admission or employment, vendors, recruiters, affiliates) may also report Title IX Sexual Misconduct against Faculty Members, Program Coordinators, Residents, or Fellows of the Program under this Policy.

HR.ER.072 Equal Employment Opportunity, Anti-Harassment and Respectful Workplace Policy  
This policy ensures all colleagues are treated in accordance with the mission and values of the organization, while in compliance with federal, state, and local laws addressing

harassment and discrimination. By outlining responsibilities and requirements for behavior and conduct; ensuring that we act in accordance with our mission, values, and applicable laws; and clearly defining the obligations to identify and report potential violations of this policy, it is the purpose of this policy to create and sustain a safe, welcoming, and productive work environment for all colleagues, patients, and visitors.

**HR.LD.007 Performance Evaluation Policy** (formerly Performance Management, HR.OP.023 and HR.305, and Performance Evaluation, HR.OP.021)

Provides guidelines to measure performance through formal performance evaluations at specific intervals, in a timely, fair, and equitable manner. Formal evaluations provide an opportunity for staff and managers to discuss and document job-related behavior and performance. While competency assessment is an element of the annual evaluation process, it is addressed in the Competency Assessment Policy. As a standard of performance common to all colleagues identified within the scope of this policy, an element of the annual performance evaluation shall include the coverage of the Code of Conduct.

**HR.TR.004 Leaves of Absence Policy** (formerly HR.OP.018 and HR.203)

Provides guidelines on eligibility, duration, documentation and reinstatement stipulations for leaves of absence provided by the Affiliated Employer; guidelines may vary by leave type and federal/state regulation.

**Information Protection and Security (IP)**

**Information Protection and Security – General (IP.GEN)**

**IP.GEN.001 Shredding Bin Use and Protection Policy**

Provides guidance regarding document-shredding bins that serve as secure, temporary storage for confidential documents until the document-shredding vendor collects the contents of the bins for final destruction processing. Provides guidelines for document-shredding bin access and key security and management, as well as direction on how to request additional bins if necessary.

**IP.GEN.003 Confidentiality Statements Policy**

Provides that all individuals with access to Company information are responsible for the protection of such information. This policy indicates when a confidentiality statement is required and how it should be utilized to make decisions regarding requests to release Company Data to External Entities.

**IP.GEN.004 Release of Company Data to External Entities Policy**

Establishes a framework for review of requests for sharing Company Data with External Entities including risk assessment, legal engagement, and approval procedures for protecting Company Data.

**Information Protection and Security – Information Security (IP.SEC, formerly IS.SEC policies)**

**IP.SEC.001 Information Security - Program Requirements Policy** (formerly IS.SEC.001)

Establishes general, high level requirements for the Company and Facility Information Security Programs. Information Security Standards, published on Atlas Connect, support these high-level requirements. The organization of the policy statements is based on an

industry standard framework (ISO 27002). One or more Information Security Standards supports each policy statement. The Standards provide more details about each of the policy statements.

**IP.SEC.002 Information Security - Electronic Communications and Digital Media Policy**  
(formerly IS.SEC.002)

Designed to protect the Company, its personnel, its patients, its data, and its resources from the risks associated with use of Company IT systems. Establishes processes to protect the Company, its personnel, its customers, and its resources from the risks associated with use of e-mail, the Internet, and other forms of electronic communication.

**IP.SEC.003 PC Software License Management Policy** (formerly IS.SEC.003, See LL.IP.002)

**IP.SEC.005 Information Confidentiality and Security Agreements Policy** (formerly IS.SEC.005)  
Promotes awareness about individual and external entity responsibility for protection of Company information, authorizes and requires agreements with individuals and external entities to acknowledge accountability for protecting Company information including confidential patient information, Social Security numbers, financial account information, personnel information, provider credentialing information, or other sensitive information regardless of format (e.g., electronic, paper, oral). Information Confidentiality and Security Agreements (CSAs) for use by Workforce Members, Non-Company Employed Practitioners, Vendors and Payers are attached to the policy.

**IP.SEC.006 Information Security Roles and Responsibilities Policy** (formerly Information Security – Facility Information Security Official, IS.SEC.006)  
Outlines information security roles and responsibilities, which establish authority and guidance for the Company to appoint a Chief Information Security Officer (CISO), for each line of business or division to appoint a Director of Information Security Assurance (DISA) or Director of Information Governance & Security (for HCA International, DIGS), and for each Company-affiliated facility to appoint a Facility Information Security Official (FISO). The individuals assigned to these roles oversee compliance with Company Information Security policies and standards and the Company Information Security program.

**IP.SEC.007 Information Protection Program – Security Committees Policy** (formerly Information Security – Security Committees Policy and formerly, Information Security Roles and Responsibilities, and formerly Information Security – Multi-Facility Security Committee, IS.AA.002 and IS.SEC.007)  
Establishes Security Committees that serve as a decision-making authority for protecting sensitive information and provide oversight of operational actions to reduce and/or eliminate risks to sensitive information through implementation of administrative, physical, and technical safeguards.

**IP.SEC.008 Information Security Agreement Policy** (formerly IS.SEC.008 and Information Security – Vendor Information Security Agreement Policy)  
Establishes contracting requirements when engaging with external entities to help prevent the introduction of security risks to our Company network, data, and/or infrastructure.

IP.SEC.009 Accounting for Risks Associated with Exceptions to Information Security Standards Policy (formerly Information Security Risk Acceptance and Accountability Policy and formerly IS.SEC.009)

Establishes procedures for business owners to request an exception to Information Security Standards and to assign financial accountability for those exceptions.

IP.SEC.020 Information Security – Physicians and Physicians Office Staff Policy (formerly IS.AA.010 and IS.SEC.020) **RETIRED**

This policy was **retired** effective October 3, 2017.

IP.SEC.021 Information Security – Monitoring of User Accounts and User Activity Policy (formerly Information Security - CPCS Conformance and Monitoring Policy and formerly Information Security – Appropriate Access Conformance and Monitoring Policy, IS.AA.014 and IS.SEC.021)

Provides facility leadership with requirements to monitor workforce member's information system user accounts and associated electronic user activity in order to detect potentially inappropriate or unauthorized access to sensitive or restricted information in support of the Company's Information Systems Account Management (ISAM) Program.

### **Information Systems**

See Information Protection and Security – Information Security (IP.SEC) for former IS.SEC policies.

IS.AA.001 CPCS Appropriate Access Policy **RETIRED**

This policy was **retired** effective December 7, 2004.

IS.AA.002 Multi-Facility Security Committee Policy

This policy has been **renumbered**. Please refer to IS.SEC.007.

IS.AA.003 Facility Security Committee Policy **RETIRED**

This policy was **retired** effective December 7, 2004

IS.AA.004 Release of and Access to Demographic and Clinical Patient Information Policy **RETIRED**

This policy was **retired** effective December 16, 2003. The requirements previously in this policy are now within Patient Privacy policies and the Appropriate Access Standards and Guidelines.

IS.AA.005 Re-disclosure of Patient Health Information Policy **RETIRED**

This policy was **retired** effective February 18, 2003.

IS.AA.006 Confidential Patient Setting in CPCS Policy **RETIRED**

This policy was **retired** effective December 7, 2004.

IS.AA.007 Sealed Patient Setting in CPCS Policy **RETIRED**

This policy was **retired** effective December 7, 2004.

IS.AA.008 PCI Menu Access Policy **RETIRED**

This policy was **retired** effective December 7, 2004.

IS.AA.009 Restrict by Location Policy **RETIRED**

This policy was **retired** effective December 7, 2004.

IS.AA.010 Physicians and Physicians Office Staff Policy

This policy has been **renumbered**. Please refer to IS.SEC.020.

IS.AA.011 External Entity Access Policy **RETIRED**

This policy was **retired** effective December 7, 2004.

IS.AA.012 Employee Health Records Policy **RETIRED**

This policy was **retired** effective May 8, 2001.

IS.AA.013 Information Security Agreement Policy **RETIRED**

This policy was **retired** effective November 13, 2001. The policy has been replaced by the Information Confidentiality and Security Agreements Policy (IS.SEC.005).

IS.AA.014 CPCS Conformance and Monitoring Policy

This policy has been **renumbered**. Please refer to IS.SEC.021.

IS.AA.015 Enforcement and Discipline Policy **RETIRED**

This policy was **retired** effective December 7, 2004.

IS.AA.025 Corporate Appropriate Access Policy **RETIRED**

This policy was **retired** effective December 7, 2004.

IS.SEC.004 Release of and Access to Casemix and Derivative Data Policy **RETIRED**

This policy was **retired** effective June 22, 2004.

IS.SEC.022 Data Protection on Portable Devices and Removable Media Policy **RETIRED**

This policy was **retired** effective November 1, 2011. See the Information Security Risk Acceptance and Accountability Policy, IS.SEC.009, and IS Standards for guidance previously in this policy.

## **Legal (LL)**

LL.001 General Statement on Agreements with Referral Sources; Approval Process Policy

Provides direction as to the Company's process for entering into financial arrangements with physicians and other potential referral sources, as defined in the policy. Any proposed exceptions must be discussed with and approved by assigned Operations Counsel and immediate supervisors prior to committing to such non-conforming proposals. Such exceptions are discouraged and only permitted where the applicable legal requirements continue to be met.

LL.002 Professional Services Agreements Policy

Provides direction as to execution of professional services agreements between affiliates of the Company and physicians, physician entities and immediate family members of physicians. Requires that Professional Services Agreements be in writing, signed by the parties, and provide for fair market value payments that are set in advance for the services actually rendered.

LL.003 Physician Recruiting Agreements Policy

Provides direction regarding recruiting arrangements between facilities and physicians. A recruitment arrangement is valid when a physician is being recruited to join the hospital's medical staff (along with meeting the other requirements of this policy). Provides guidance regarding recruiting a physician into an existing practice.

**LL.004 Physician and Referral Source Real Estate Transactions; Physician and Referral Source Space Leases Policy** (formerly Physician Real Estate Transactions; Physician Space and/or Equipment Leases Policy, Physician Equipment or Space Leases Policy, and formerly Physician Real Estate Transactions; Physician Space Leases Policy)

Provides direction with respect to Real Property Transactions between HCA Healthcare Affiliates and Referral Sources.

**LL.005 Physician Management Services Agreements/Business Office Services Agreements/HCAPS Contract Services Policy**

Ensures compliance with all applicable federal and state laws, including, without limitation, Stark II and the Anti-Kickback Statute, and to promote sound business judgments in connection with management agreements whereby the Company provides management services, business office services, and/or HCA Physician Services (HCAPS) on behalf of a physician or physician entity in exchange for a fair market value management fee unrelated to a medical practice acquisition or Equity MSO.

**LL.006 Physician Employment Policy**

Ensures compliance with all applicable federal and state law, including, without limitation, Stark II and the Anti-Kickback Statute, and promotes sound business judgment in connection with arrangements for physician employment.

**LL.007 Medical Practice Asset Acquisitions Policy**

Ensures compliance with all applicable federal and state laws, including, without limitation, Stark II and the Anti-Kickback Statute, and to promote sound business judgments in connection with medical practice asset acquisitions. Requires approvals which vary based on total purchase price. Requires the transaction and requisite documents be approved by the Legal Department.

**LL.008 Physician Equity MSOs Policy**

Ensures compliance with all applicable federal and state laws, including, without limitation, Stark II and the Anti-Kickback Statute, and promotes sound business judgments in connection with forming Equity Management Services Organizations ("MSOs"), typically through pro rata contributions of practice assets and cash.

**LL.009 Loans and Loan Guaranties Policy**

Provides that no loan or loan guaranty may be entered with any physician group or any one or more individual physicians (or family member of a physician) except in the context of a physician recruitment arrangement where amounts owed to the Company by the recruited physician may be converted to a loan consistent with the policy specifically addressing physician recruitment arrangements or if an exception is approved as outlined in the policy.

**LL.010 Non-Employed Physician Education Expenses Policy**

The policy ensures that payment or reimbursement of expenses incurred by a non-employed physician for conferences or continuing education courses, including tuition,

travel, room and board, and similar expenses be provided to the physician free of charge only in a highly limited number of circumstances. In all other circumstances, a physician must be charged the fair market value of the education and related expenses.

**LL.011 Providing Free and/or Discounted Training and Equipment to Referral Sources Policy**

Provides direction as to the provision of free and/or discounted training and the extension of the use of equipment (e.g., computers) to non-employed physicians and their office staff. Requires the facility to establish a set of criteria to provide training or equipment to physicians. Training and equipment may be afforded to employed physicians by their employer without consideration.

**LL.012 Physician Access to Vendor Agreements Policy**

Provides guidance on when non-employed physicians may purchase products or services under HPG, Division, Market or facility contracts with vendors ("Vendor Contracts"). Facilities must not sell items from their inventory to non-employed physicians if the items were purchased under an HPG vendor contract, except as otherwise stated in the policy.

**LL.013 Physician Referral Services Policy**

Provides direction as to the operation of referral services by the Company or by any of its facilities. It is not intended to address direct referrals by physicians or other health care providers, but it is instead intended to apply only to organized physician referral services through dedicated telephone numbers and similar methods.

**LL.014 Servicing Patients in Assisted Living Facilities (ALFs) Policy**

Provides direction to home health agencies in providing home health services, including Home Health Aides' services, to patients residing in Assisted Living Facilities (ALFs). Establishes that use of home health aides in an ALF should be provided on an exception basis only after a determination has been made that a service is not duplicative or the appropriate circumstance exists.

**LL.015 Home Health Community Education Record Keeping/Reimbursement Policy **RETIRED****

This policy was **retired** effective June 30, 2021. Please refer to the Identification of Non-Allowable Costs Policy, RB.004, for information on excluding non-allowable costs for home health agencies.

**LL.016 Discharge Planning: Patient Choice for Post-Acute Providers/Services upon Discharge Policy (formerly Discharge Planning and Referrals of Patients to Post Discharge Providers Policy; and LL.HH.016)**

A Hospital, as part of its effective Discharge Planning process, must focus on the patient's goals and treatment preferences and include the patient and their caregivers/support persons as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and their treatment preferences, ensure an effective transition of the patient from the Hospital to post-discharge care, and reduce the factors leading to preventable hospital admissions.

The Hospital must inform the patient of their freedom of choice in selecting their Post-Acute Provider/Service and of any Disclosable Financial Interest the Hospital has in, or with respect to, such Post-Acute Provider/Service. The Hospital must assist the patient in selecting a Post-Acute Provider/Service by using and sharing data that includes, but is



not limited to, SNF, HHA, IRF or LTCH data on quality measures and resource use measures that is relevant and applicable to the patient's care goals and treatment preferences.

Patients discharged to a SNF, HHA, IRF or LTCH must be provided with a list of such Post-Acute Providers/Services in the patient's geographic area. The Hospital must respect, when possible, the patient's goals of care and treatment preferences, as well as other preferences, when expressed by the patient and/or the patient's representative.

**LL.017 Medical Practice Asset Divestitures Policy**

Ensures compliance with all applicable federal and state laws, including, without limitation, Stark II and the Anti-Kickback Statute, and to promote sound business judgments in connection with medical practice divestitures. Requires approvals which vary based on total purchase price. Requires the transaction and requisite documents be approved by the Legal Department.

**LL.018 Professional Courtesy Discounts Policy**

Establishes guidelines for extending professional courtesy discounts to physicians and their immediate family members. Requires that a facility that wishes to extend such discounts must adopt a written professional courtesy policy regarding the extension of discounts that is consistent with the limitations in the policy and that the facility's governing body approve the policy in advance of its implementation.

**LL.019 Provider-Based Program Development, Operations and Compliance Policy**

Establishes guidelines for the development of, and compliance with requirements, for Provider-Based Programs. Establishes guidelines relevant to service agreements where Providers purchase/lease certain components of patient care services (e.g., management expertise, equipment, technical staff, supplies) for the Provider-Based Programs from third party entities. Establishes additional requirements specific to certain Provider-Based Programs that fall under the scope of the provider-based regulations in 42 CFR Section 413.65.

**LL.020 Physician Relationship Training Policy**

Ensures that all Required Individuals, as defined in the policy, receive training regarding Physician Relationships, as defined in the policy, and are aware of current laws and regulations related to Physician Relationships, including but not limited to the Federal anti-kickback statute and the Federal physician self-referral statute. Requires that participation in Physician Relationship training be completed using resources identified in the policy and tracked using the Company's HealthStream Learning Center (HLC).

**LL.021 Physician Purchasing Items or Services from the Facility Policy**

Establishes guidelines under which a physician or physician group may purchase items or services from a facility or corporate department. Provides that, subject to the requirements of the Physician Access to Vendor Agreements Policy (LL.012), any physician or physician group may purchase items or services from a facility or corporate department at fair market value.

**LL.022 Reimbursement of Expenses and Extending Tokens Related to Voluntary Leadership Service by Potential Referral Sources Policy (formerly EC.009)**

Establishes guidelines for: a) reimbursing (or paying directly for) expenses incurred by potential referral sources when undertaking voluntary leadership efforts on behalf of the

Company or a Company-affiliated facility; and b) extending tokens of appreciation in recognition of voluntary leadership efforts by potential referral sources on behalf of the Company or Company-affiliated facility. Examples of such efforts include attendance at meetings of hospital boards and medical executive committees, and conferences relevant to their hospital duties.

LL.023 Marketing Activities Involving Physicians Policy (formerly Marketing Physicians Policy)  
Establishes requirements and guidelines for marketing activities involving Independent Physicians and/or their practices, as well as Employed or Engaged Physicians and/or their practices. The policy addresses the general circumstances pursuant to which an HCA Affiliate may pay for marketing that includes physicians, depending on the status of the physician (e.g., employed vs. independent), and who primarily benefits from the Marketing Activity.

LL.024 Use of Facility-Owned Space by Potential Referral Sources Policy (formerly Use of Facility-Owned Space by Physicians)  
Establishes parameters for allowing a non-employed physician, or immediate family member of a non-employed physician, to use facility space for meetings and gatherings. The policy permits non-employed physicians, their immediate family members, and health-related 501(c)(3) organizations to use common spaces on facility property as a forum for speaking events only if the primary purpose of the use of the space is to benefit the facility or a 501(c)(3) organization, or the physician or physician group using the space pays fair market rental value for the use of the space. This policy does not apply to employed physicians.

LL.025 Fair Market Valuations Policy  
Provides direction as to the Company's process of determining whether a transaction with a potential referral source is made at fair market value (FMV) in order to comply with Stark Law and the Anti-kickback Statute. This policy provides guidance regarding what constitutes FMV in various types of arrangements.

LL.026 Physician Access to the Internet Policy (formerly EC.013)  
Authorizes facilities to provide affiliated physicians with Internet access for professional use so long as such facilities have bona fide medical staffs and the purpose of accessing the Internet relates to patient care. Provides guidance regarding guidelines for, and location of, such access.

LL.027 Relationships with Physician-Connected Vendors Policy (formerly Physician-Owned Vendor Relations Policy)  
This policy is intended to guide purchases of items and services from Vendors that are owned in whole or in part by Physicians or that have compensation arrangements with Physicians. This policy must be read in conjunction with the Prohibition on Purchasing Certain Products from Physician-Owned Businesses Policy, LL.029.

LL.028 Limitation on Entering into Expense Sharing Arrangements and Space Distribution Arrangements Policy (formerly Limitation on Entering into Expense Sharing Agreements Policy)  
Establishes limits on any Company-affiliated entity from entering into any expense sharing arrangement or space distribution arrangement with or on behalf of a physician or physician practice. This policy explicitly limits the use of expense sharing

arrangements and is **not** intended to restrict the execution of other arrangements including but not limited to time sharing agreements with any physician group or any one or more individual physicians.

**LL.029 Prohibition on Purchasing Certain Products from Physician-Owned Businesses Policy**

This policy is intended to prohibit the Company from purchasing certain covered products from certain physician-owned businesses. This policy must be read in conjunction with the Relationships with Physician-Connected Vendors Policy, LL.027.

**LL.030 Non-physician Practitioner Recruiting Assistance Agreements Policy**

This policy provides direction regarding Non-physician Practitioner Recruiting Assistance Agreements by and among a hospital, a Physician (and a Physician Organization, if applicable) and a Qualified Non-physician Practitioner (QNP).

**LL.031 Discharge Transportation Services Program**

This policy permits the establishment of complimentary Discharge Transportation Services following inpatient admission or Emergency Department Services. The policy articulates the approved methods for such transportation but prohibits the use of ambulance or luxury transportation consistent with the Anti-kickback Statute Local Transportation Safe Harbor. The policy identifies other limitations as well as the recordkeeping requirements.

**LL.AC.001 Global Anti-Corruption Policy**

Promotes compliance by all HCA Healthcare Employees and Colleagues with the anti-corruption laws that apply to Company operations, including the U.S. Foreign Corrupt Practices Act ("FCPA") and the anti-corruption laws of Foreign Countries in which HCA Healthcare conducts business. This policy focuses on interactions with Foreign Officials, but Employees and Colleagues should be aware that the laws of some countries in which HCA Healthcare operates prohibit the bribery of any person (not merely bribery of Foreign Officials). Employees and Colleagues must comply with the anti-corruption laws in their respective jurisdictions and those of other jurisdictions that apply to them.

**LL.AC.001- India HCA Global Services India Anti-Corruption Policy**

This is an anti-corruption / anti-bribery policy specifically applicable to HCA's Global Capability Center (GCC), HCA Global Services India. Directors, Employees, and Third-Party Representatives are prohibited from corruptly offering, promising, authorizing, giving, or attempting to give, directly or indirectly through a third party, Anything of Value<sup>i</sup> to any person, including any Government Official or employee of a commercial customer or supplier, in order to:

- get or keep business,
- gain an improper business advantage,
- influence the recipient to act in favor of the Company or the third party,
- induce the recipient to perform his or her job functions in favor of the Company or the third party, or
- thank the recipient for improperly directing business or giving a business advantage to the Company or the third party.

There are additional requirements and protocols for hiring third-parties that may interact with Government Officials on behalf of the GCC.

LL.EM.001 EMTALA – Definitions and General Requirements Policy (formerly EMTALA - Medical Screening Policy, RI.001)

Requires, in conjunction with state-specific policies, that an acute care or specialty hospital with an emergency department provide an appropriate medical screening examination and any necessary stabilizing treatment to any individual, including every infant who is born alive, at any stage of development, who comes to the Emergency Department and requests such examination, as required by the Emergency Medical Treatment and Labor Act (“EMTALA”), 42 U.S.C., Section 1395dd and all Federal regulations and interpretive guidelines promulgated thereunder.

LL.EM.002 EMTALA – Stabilization Policy (formerly RI.002) **RETIRED**

This policy was **retired** effective July 15, 2008. This policy has been replaced by the state-specific sample facility policy, EMTALA – Medical Screening Examination and Stabilization Policy.

LL.EM.003 EMTALA – Transfer Policy (formerly RI.003) **RETIRED**

This policy was **retired** effective July 15, 2008. This policy has been replaced by the state-specific sample facility policy, EMTALA – Transfer Policy.

LL.EM.004 EMTALA – Signage Policy (formerly RI.004) **RETIRED**

This policy was **retired** effective July 15, 2008. This policy has been replaced by the state-specific sample facility policy, EMTALA – Signage Policy.

LL.EM.005 EMTALA – Central Log Policy (formerly RI.005) **RETIRED**

This policy was **retired** effective July 15, 2008. This policy has been replaced by the state-specific sample facility policy, EMTALA – Central Log Policy.

LL.EM.006 EMTALA – Duty to Accept Policy (formerly RI.006) **RETIRED**

This policy was **retired** effective July 15, 2008. This policy has been replaced by the state-specific sample facility policy, EMTALA – Transfer Policy.

LL.EM.007 EMTALA – Provision of On-Call Coverage Policy (formerly RI.007) **RETIRED**

This policy was **retired** effective July 15, 2008. This policy has been replaced by the state-specific sample facility policy, EMTALA – Provision of On-Call Coverage Policy.

LL.EM.008 EMTALA – Hospital Based Departments both On and Off Campus Policy (formerly EMTALA – Hospital Departments both On and Off Campus and On-Campus Hospital Based Entities and RI.008) **RETIRED**

This policy was **retired** effective December 7, 2004.

LL.GEN.001 Waiver of Medicare Copays and Deductibles; Offering of Additional Benefits Policy

Establishes specific and limited circumstances under which it is permissible for a Company healthcare facility to waive or reduce a Medicare beneficiary’s obligation to pay coinsurance or deductible amounts owed for the provision of medical services.

LL.GEN.002 Copyright Policy

Ensures compliance with copyright laws and licensing requirements and avoidance of infringement of copyrights. The Company has signed license agreements with various companies pertaining to copyrighted materials in a variety of formats. For printed materials, the license agreement is with the Copyright Clearance Center (CCC), for

music, the agreements are with BMI, ASCAP, SESAC and Global Music Rights, and for pre-recorded videos or DVDs, the license agreement is with the Motion Picture Licensing Corporation (MPLC).

**LL.GEN.003 Communications with Competitors Concerning Prices, Costs of Service and other Competitively Sensitive Topics Policy**

Provides limitations on information exchanges with Competitors, designed both to aid compliance with antitrust laws and to protect HCA Healthcare Affiliates' competitive and financial interests. The policy outlines prohibited and permitted communications and addresses surveys, recruitment, employment verification, business transactions and seminars and trade meetings.

**LL.IP.001 Trademark Policy**

This policy protects the Company's trademarks and ensures compliance with trademark laws and avoids infringement of trademarks. Requires Company colleagues to not use any trademarks or service marks that may result in a likelihood of confusion with the source-identifying trademarks or service marks of others in violation of trademark law.

**LL.IP.002 PC Software License Management Policy (formerly IS.SEC.003)**

Ensures compliance with all software license agreements' terms and conditions and copyright laws. Requires that each facility or department designate an individual, or individuals, to serve in the capacity of Facility IT&S Director or Software License Management Representative (SLMR) to be responsible for enforcing this policy and delineates the responsibilities of the IT Director or SLMR.

**LL.MBP.001 Medicare Bundled Payment Policy**

Sets forth the general parameters governing CMS bundled payment programs and provides guidance for participant facilities. In light of the growing prominence of CMS bundled payment programs, the Company seeks to educate participant facilities regarding applicable program requirements and facilitate compliance efforts and administration of such programs.

**LL.MBP.002 Medicare Bundled Payments: CJR Collaborator Selection Criteria Policy**

Establishes the Selection Criteria for use by hospitals that are participants in the CMS Comprehensive Care for Joint Replacement (CJR) Bundled Payment Program and which choose to participate in gainsharing pursuant to that program.

**LL.SEC.001 Securities Trading Policy**

Provides direction regarding transactions in publicly traded securities of HCA Healthcare and certain other companies and promotes compliance with the applicable law. The policy applies to all colleagues of HCA Healthcare affiliates and subsidiaries and members of HCA Healthcare's Board of Directors. Transactions in HCA Healthcare common stock or other publicly traded securities of HCA Healthcare may not be effected when an individual is aware of material, nonpublic information relating to HCA Healthcare, nor may material, nonpublic information relating to HCA Healthcare (or its suppliers, partners, customers or competitors) be shared with friends, family members or others who do not need the information as part of their work for HCA Healthcare.

**LL.SEC.002 Corporate Disclosure Policy**

Provides guidelines and procedures used by HCA Healthcare in making required public

disclosures of material information on a broadly disseminated basis and in a manner that provides to all stockholders, investors and securities market professionals the opportunity for equal access to such information consistent with Regulation FD and other legal and regulatory requirements.

## **Materials Management (MM)**

### **MM.001 Prohibition against Contracting with Any Ineligible Person Policy**

Ensures that the Company does not contract with any Ineligible Person or persons who are excluded from participation in an applicable state healthcare program. Defines “Ineligible Person” and requires that appropriate personnel search the HHS/OIG List of Excluded Individuals/Entities, the General Service Administration’s exclusion records in the System for Award Management (SAM), and applicable state exclusion lists, to determine that a proposed contractor is not an Ineligible Person. Includes procedural guidelines, including documentation requirements for national agreements, facility contracts, and corporate contracts.

### **MM.002 Vendor Relations Policy **RETIRED****

This policy was **retired** effective September 1, 2020. This policy has been replaced by the Vendor Relations Policy, EC.028.

### **MM.003 HealthTrust Purchasing Group Personnel Conflict of Interest Policy **RETIRED****

This policy was **retired** effective February 5, 2013. This policy has been replaced by the HealthTrust Purchasing Group Conflict of Interest Policy, HT.003.

### **MM.004 Educational Funding from Vendors Policy **RETIRED****

This policy was **retired** effective September 1, 2020. This policy has been replaced by the Professional Educational Funding from Vendors Policy, EC.029.

### **MM.005 Research Grant Funding from Vendors Policy **RETIRED****

This policy was **retired** effective May 18, 2021.

## **Patient Experience (PE)**

### **PE.CA.001 Excluding Patients from the Patient Survey Process Policy (formerly CSG.CA.001)**

Establishes a protocol to exclude patients who wish to opt out of the patient survey process.

## **Payroll (PAY)**

### **PAY.001 Awards of Gift Cards and Gift Certificates Policy**

Ensures all gift cards and gift certificates transferred from a Company-affiliated employer to Company-affiliated colleagues are treated as income to the employee in accordance with IRS regulations.

## **Privacy (formerly IP.PRI policies & HIM.PRI policies)**

### **Privacy – Data Protection (PRIV.DP)**

#### **PRIV.DP.AK.019, Breach of Security Involving Personal Information (formerly IP.DP.AK.019)**

Provides guidance regarding workforce members’ responsibility related to procedures and protocols for identifying and responding to a breach of the security of data that includes personal information. To establish the requirements for each Company-affiliated

facility in Alaska to protect computerized personal information as required by the Alaska Personal Information Protection Act, Alaska Statute 45.48.010 through 45.48.090.

PRIV.DP.CA.001, California Consumer Privacy Act of 2018 (CCPA) as Amended by the California Privacy Act (CPRA) and Data Breaches\_(Formerly IP.DP.CA.001)

Establishes Company policy for compliance with the California Consumer Privacy Act (CCPA) and establishes the requirements for each Company-affiliated facility in California when it may have failed to protect the privacy and security of medical information and other personal information (PI) under California state law, to outline the applicable state notification requirements in the event of a reportable incident. Provides guidance regarding workforce members' responsibilities related to potential security breaches involving PI and the potential improper access to, use or disclosure of medical information.

PRIV.DP.CO.004, Colorado - Breach of Personal Information under Colorado's Consumer Data Privacy Law and the Treatment of Personal Data Under the Colorado Privacy Act (CPA) (formerly Breach of Personal Information under Colorado's Consumer Data Privacy Law Policy) (formerly IP.DP.CO.004)

Establishes Company policy for compliance with the Colorado Data Privacy Law and establishes the requirements for each Company-affiliated facility in Colorado when it may have failed to protect the privacy and security of medical information and other personal information (PI) and to outline the applicable state notification requirements in the event of a reportable incident. Provides guidance regarding workforce members' responsibilities related to potential security breaches involving PI and the potential improper access to, use or disclosure of medical information. Establishes Company policy for compliance with the Colorado Privacy Act (CPA) and establishes the requirements for each Company-affiliated facility in Colorado when it may receive a personal data request from a Colorado resident.

PRIV.DP.FL.005, Breach of Confidential Information under the Florida Information Protection Act of 2014\_(formerly IP.DP.FL.005)

Provides guidance regarding workforce members' responsibility related to data breaches and establishes the requirements for each Company-affiliated facility in Florida to protect confidential personal information as required by The Florida Information Protection Act of 2014, effective July 1, 2014.

PRIV.DP.GA.009, Breach of Personal Information under Georgia's Personal Identity Protection Act\_(formerly IP.DP.GA.009)

Provides guidance regarding workforce members' responsibility related to procedures and protocols for identifying and responding to an incident involving a breach of security of the system involving the unauthorized acquisition and use of an individual's personal information. To establish the requirements for each Company-affiliated facility in Georgia to protect personal information as required by Georgia Code Annotated § 10-1-910 et seq., effective May 24, 2007.

PRIV.DP.ID.014, Idaho - Security Breach of Computerized Information\_(formerly IP.DP.ID.014)

The policy will provide guidance regarding workforce members' responsibility related to procedures and protocols for identifying and responding to an incident involving a breach of security of the system involving the unauthorized acquisition and use of an individual's personal information. To establish the requirements for each Company-affiliated facility

in Idaho to protect computerized personal information as required by Idaho Code 28-51-104 to 28-51-107.

PRIV.DP.IN.017, Indiana - Disclosure of Security Breaches and Notification Process (formerly IP.DP.IN.017)

Provides guidance regarding workforce members' responsibility related to procedures and protocols for identifying and responding to a breach of the security of data that includes personal information. To establish the requirements for each Company-affiliated facility in Indiana to protect computerized personal information as required by Indiana Code Title 24, Sections 4.9-1-1 to 4.9-4-2.

PRIV.DP.KY.016, Breach of Security of Computerized Unencrypted Personally Identifiable Information (formerly IP.DP.KY.016)

Provides guidance regarding workforce members' responsibility related to procedures and protocols for identifying and responding to a breach of security of data that includes personal information. To establish the requirements for each Company-affiliated facility in Kentucky to protect computerized personal information as required by Kentucky Revised Statutes Section 365.732.

PRIV.DP.KS.013, Kansas - Consumer Information and Security Breach Requirements (formerly IP.DP.KS.013)

The policy will provide guidance regarding workforce members' responsibility related to breach of systems containing consumer personal information. Establishes the requirements for destruction of consumer's records as well as each Company-affiliated facility in Kansas to protect personal information as required by Kansas Statutes Annotated (K.S.A.) § 50-7a01, § 50-7a02, and § 50-7a03.

PRIV.DP.LA.006, Breach of Personal Information under the Louisiana Database Security Breach Notification Law (formerly IP.DP.LA.006)

Provides guidance regarding workforce members' responsibility related to electronic database security breaches of certain confidential personal information and establishes the requirements for each Company-affiliated facility in Louisiana to protect confidential personal information as required by Database Security Breach Notification Law, as amended by Acts 2018, No. 382, effective August 1, 2018.

PRIV.DP.MO.012, Missouri Notice to Consumer for Breach of Security of Personal Information (formerly IP.DP.MO.012)

Provides guidance regarding workforce members' responsibility related to data breaches and establish the requirements for each Company-affiliated facility in Missouri to protect consumers' personal information in the Missouri Revised Statute, Section 407.1500, effective August 28, 2009.

PRIV.DP.NC.007, North Carolina Identity Theft Act: Breach of Personal and Identifying Information (formerly IP.DP.NC.007)

Provides guidance regarding workforce members' responsibility related to procedures and protocols for identifying and responding to an incident involving the unauthorized disclosure of unencrypted personal information, in compliance with the Identity Theft Protection Act of 2005, North Carolina General Statutes § 7560 et seq. and § 132-1.10 of the Public Records Act.



PRIV.DP.NH.018, New Hampshire - Notice of Security Breach (formerly IP.DP.NH.018)  
Provides guidance regarding workforce members' responsibility related to procedures and protocols for identifying and responding to a breach of security of computerized data that includes personal information. To establish the requirements for each Company-affiliated facility in New Hampshire to protect computerized personal information as required by New Hampshire Chapter 359-C, Section 359-C-19 and New Hampshire Chapter 332-I, Section 332-I:5.

PRIV.DP.NV.003, Nevada – Notice Regarding Privacy of Personally Identifiable Information Collected on the Internet from Consumers (formerly IP.DP.NV.003)  
This policy establishes the requirements for each Company-affiliated legal entity in the state of Nevada to post an online Notice regarding Covered Information collected by Operator as required by N.R.S. 603A.340. The online Notice will include a statement informing Consumers of their right to opt-out of the Sale of their Covered Information and a designated request address through which consumers may submit verified requests to opt-out of the Sale of their Covered Information.

PRIV.DP.SC.011, South Carolina Breach of Security of Business Data Containing Personal Identifying Information (formerly IP.DP.SC.011)  
Provides guidance regarding workforce members' responsibility related to data breaches and establish the requirements for each Company-affiliated facility in South Carolina to protect personal information as required by South Carolina Breach of Security of Business Data law, effective April 23, 2013.

PRIV.DP.TN.008, Tennessee - Breach of Personal Information under the Identity Theft Deterrence Law (formerly IP.DP.TN.008)  
To provide guidance regarding workforce members' responsibility related to procedures and protocols for identifying and responding to an incident involving the unauthorized disclosure of unencrypted personal information, in compliance with the Release of Personal Consumer Information under Tennessee Code Annotated § 47-18-2107.

PRIV.DP.TX.002, Breach of Personal Identifying Information under the Texas Identity Theft Enforcement and Protection Act (formerly IP.DP.TX.002)  
This policy provides guidance regarding workforce members' responsibility related to procedures and protocols for identifying and responding to an incident involving the unauthorized use or possession of personal identifying information, in compliance with the Texas Identity Theft Enforcement and Protection Act.

PRIV.DP.UT.015, Utah - Protection of Personal Information Act (formerly IP.DP.UT.015)  
To provide guidance regarding workforce members' responsibility for identifying and responding to a security breach, in compliance with Utah Code §§ 13-44-101 et seq., Protection of Personal Information Act.

PRIV.DP.VA.010, Virginia - Breach of Personal and/or Medical Information Notification (formerly IP.DP.VA.010)  
Provides guidance regarding workforce members' responsibility related to breach notification of personal and/or medical information and to establish the requirements for each Company-affiliated facility in Virginia of the breach notification laws as required by

the Code of Virginia, Section 18.2-186.6 Breach of Personal Information Notification and Section 32.1-127.1:05 Breach of Medical Information Notification.

## **Privacy – General (PRIV.GEN)**

PRIV.GEN.002, Protecting and Mitigating Inappropriate or Unauthorized Access, Use and/or Disclosure of Personally-Identifiable Information (PII) Policy (formerly Protecting Personally-Identifiable Information (PII) Policy) (formerly IP.GEN.002)

Provides guidance that all facilities are responsible for the protection of personally identifiable information (PII). This policy illustrates the areas in which appropriate actions must be taken to ensure the use of PII is limited and protected.

PRIV.GEN.005, Global Privacy Policy - General Data Protection Regulation (IP.GEN.005)

Establishes Company policy (in all territories worldwide) for compliance with the General Data Protection Regulation (GDPR), 2016 and any other applicable Data Protection Laws.

PRIV.GEN.006, Information Blocking Rule Compliance Policy (IP.GEN.006)

Establishes the requirements for compliance with the Information Blocking Rules, 45 CFR Part 171, promulgated by the Office of the National Coordinator for Health Information Technology in order to implement Section 4004 of the 21st Century Cures Act of 2016.

## **Privacy – HIPAA (PRIV.HIPAA)**

PRIV.HIP.001 Patient Privacy – Program Requirements Policy (formerly IP.PRI.001 & HIM.PRI.001)

Establishes general requirements for the patient privacy program, provides pertinent definitions and guidance for some aspects of the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), and the Health Information Technology for Economic and Clinical Health Act (HITECH) component of the American Recovery and Reinvestment Act of 2009 (ARRA). Attachment A to the policy is a series of Model Facility Policies.

PRIV.HIP.002 Privacy Official Policy (formerly IP.PRI.002 & HIM.PRI.002)

Ensures each Company-affiliated facility has a Facility Privacy Official (FPO), to meet the requirement of the HIPAA Privacy Standards and to ensure each Company-affiliated hospital and shared services center (SSC) establishes or identifies an existing committee to be designated with the facility's Privacy Program oversight.

PRIV.HIP.003 Minimum Necessary Policy (formerly IP.PRI.003 & HIM.PRI.003)

Provides guidance regarding each workforce member's responsibility related to using and disclosing only the minimum amount of identifiable patient information to fulfill the purpose of the use or disclosure, regardless of the extent of access provided. This policy covers uses and disclosures of protected health information (PHI) in any form including oral, written and/or electronic mediums. Each individual is responsible for adhering to

this policy by using only the minimum information necessary to perform their responsibilities, regardless of the extent of access provided or available.

**PRIV.HIP.004 Patient Privacy – Patients’ Right to Access Policy (formerly IP.PRI.004 & HIM.PRI.004)**

Provides guidance regarding patients’ rights to inspect and/or obtain a copy of their PHI as required by the HIPAA Privacy Standards and the HITECH Act. Provides guidance on patients’ rights to inspect and obtain a paper copy of their PHI that is contained within the designated record set, exceptions thereto, and circumstances when the facility may deny a request.

**PRIV.HIP.005 Patient Privacy – Patients’ Right to Amend Policy (formerly IP.PRI.005 & HIM.PRI.005)**

Ensures patients the right to amend protected health information (PHI) stored in the designated record set as required by the HIPAA Privacy Standards. Provides guidance on patients’ rights to request the facility amend their PHI that is contained within the designated record set for as long as the information is maintained by the facility and exceptions thereto.

**PRIV.HIP.006 Patient Privacy – Right to Request Privacy Restrictions Policy (formerly IP.PRI.006 & HIM.PRI.006)**

Ensures patients the right to request privacy restrictions on the use or disclosure of their PHI as required by the HIPAA Privacy Standards and the HITECH Act. Provides guidance on patients’ right to request restriction of certain uses and disclosures of their PHI that is contained within the designated record set. Provides guidance regarding exceptions to this right and circumstances under which a request may be denied.

**PRIV.HIP.007 Notice of Privacy Practices Policy (formerly IP.PRI.007 & HIM.PRI.007)**

Ensures that each facility understands the requirement to provide a Notice of Privacy Practices to all patients as required by the HIPAA Privacy Standards. Requires each facility to provide a Notice of Privacy Practices to all patients. Provides that the facility must inform patients of their rights with respect to PHI as well as the facility’s legal duties and that the patient must acknowledge receipt of the notice. All notices must include all the elements in the version attached to the policy and must have the name or title and telephone number of the FPO.

**PRIV.HIP.008 Patient Privacy – Right to Request Confidential Communications Policy (formerly IP.PRI.008 & HIM.PRI.008)**

Provides guidance regarding a patient’s right to request Confidential Communications as required by the HIPAA Privacy Standards. Patients will be provided the right to request Confidential Communications by alternative means or to alternative locations and that such requests must be accommodated if reasonable. Confidential Communications pertain to correspondence and communication related to the specific visit(s) stated in the request.

**PRIV.HIP.009 Patient Privacy – Accounting of Disclosures Policy (formerly IP.PRI.009 & HIM.PRI.009)**

Provides guidance regarding the requirement to populate and provide an Accounting of Disclosures (AOD) of protected health information (PHI) to all patients as required by the HIPAA Privacy Standards. States that each facility must provide a written AOD of PHI to

individuals that a facility has made during the six years prior to the date on which the accounting is requested. Requires that a system be in place for all departments (including but not limited to: Radiology, Quality, Emergency Room, and Health Information Management) within the facility to accurately and completely track all disclosures and have such information available for a minimum of six years as required by the HIPAA Privacy Standards and the policy.

**PRIV.HIP.010 Authorization for Uses and Disclosures of Protected Health Information Policy**  
(formerly IP.PRI.010 & HIM.PRI.010)

Establishes the requirements for each Company-affiliated facility to utilize patient authorizations to use or disclose PHI as required by the HIPAA Privacy Standards and all Federal regulations and interpretive guidelines promulgated thereunder. A patient's HIPAA compliant authorization is not required for a facility's own payment, treatment and limited healthcare operations activities.

**PRIV.HIP.011 Protected Health Information Breach Risk Assessment and Notification Policy**  
(formerly IP.PRI.011, Protected Health Information Breach Notification & HIM.PRI.011)

Facilitates compliance with the Health Information Technology for Economic and Clinical Health Act (HITECH) component of the American Recovery and Reinvestment Act of 2009 (ARRA) breach notification of unsecured protected health information (PHI) requirements. Requires Company-affiliated facilities, in the case of a breach of unsecured PHI, to notify the patient or their personal representative without unreasonable delay and in no case later than 60 days of discovering the breach.

**PRIV.HIP.012 Safeguarding Protected Health Information Policy** (formerly IP.PRI.012 & HIM.PRI.012)

Establishes guidelines for protecting and safeguarding protected health information (PHI). Requires facilities to take reasonable steps to safeguard and protect PHI. Facilities must identify and utilize appropriate administrative, physical, and technical safeguards in order to protect PHI from inappropriate and/or unauthorized access, use, and/or disclosures.

**PRIV.HIP.013 Mitigating Inappropriate or Unauthorized Access, Use and/or Disclosure of Protected Health Information Policy** (formerly IP.PRI.013 & HIM.PRI.013)

Establishes guidelines for mitigating inappropriate or unauthorized access, use and/or disclosure of protected health information (PHI). In order to protect PHI when inappropriate or unauthorized access, use, and/or disclosure of PHI occurs, facilities must take immediate, reasonable steps to mitigate the situation. Facilities must review the administrative, physical, and technical safeguards in place to help ensure PHI is protected from further inappropriate and/or unauthorized access, use, and/or disclosure.

**Quality Management** – See Clinical Operations Group (COG, formerly Clinical Services Group (CSG))

**Regulatory Compliance Support (REGS, formerly Governmental Operations Support & HIMS Coding)**

**REGS.APS.001 Physician Certification and Recertification for Post-Acute Services Policy**  
(formerly GOS.APS.001)

Outlines the Medicare requirements for physician certification and recertification for post-acute services. Post-Acute Services includes Inpatient Psychiatric Facilities (IPF)

(includes hospitals and distinct part units), Inpatient Rehabilitation Facilities (IRF) (includes hospitals and distinct part units), Skilled Nursing Facilities (SNF), Swing Bed Facilities, Outpatient Physical Therapy (PT), Occupational Therapy (OT) and Speech-Language Pathology (SLP) Services, Partial Hospitalization Programs (PHP), and Intensive Outpatient Programs (IOP). The certification/recertification must be completed, signed, and dated by a physician or applicable allied health practitioner for all post-acute services.

REGS.APS.002 Outpatient Rehabilitation Therapy Services Policy (formerly GOS.APS.002)  
This policy outlines required billing guidelines for Medicare outpatient rehabilitation therapy services.

REGS.BILL.001 Outpatient Services and Medicare Three Day Window Policy (formerly GOS.BILL.001) **RETIRED**  
This policy was **retired** effective December 1, 2007. The Outpatient Services and Medicare Three Day Window Policy (REGS.GEN.009) includes guidance previously in this policy.

REGS.BILL.002 Collection of Financial Information in the Emergency Department Policy (formerly GOS.BILL.002) **RETIRED**  
This policy was **retired** effective September 9, 2015.

REGS.BILL.003 Outpatient Self-Administered Drugs Policy (formerly GOS.BILL.003)  
Outlines the billing requirements for outpatient self-administered drugs. Most outpatient self-administered drugs are statutorily excluded from the Medicare program and must not be billed as covered services. Charges for non-covered self-administered drugs for Medicare outpatients may be discounted or waived.

REGS.BILL.005 Confirming and Processing Overpayments Policy (formerly GOS.BILL.005) **RETIRED**  
This policy was **retired** effective January 1, 2017.

REGS.BILL.006 Stat, Call Back, Stand-by and Handling Charges Policy (formerly GOS.BILL.006)  
Establishes guidelines for billing stat, call back, stand-by and handling charges in accordance with Medicare, Medicaid, or other federally-funded programs. Requires that the CFO determine if stat, call back, stand-by and handling charges will be billed to non-federally-funded payers and provides guidance on procedures to follow based on CFO's determination.

REGS.BILL.007 Billing for Investigational Devices in Clinical Trials Policy (formerly Billing for Investigational Devices and Related Services Policy, GOS.BILL.007)  
Describes the hospital process for billing for investigational devices and the routine costs associated with such devices in clinical trials.

REGS.COD.001 Coding Documentation for Inpatient Services Policy (formerly HIM.COD.001)  
Improves the accuracy, integrity and quality of patient data, ensures minimal variation in coding practices, and improves the quality of the physician documentation within the body of the medical record to support code assignments.

REGS.COD.002 Coding Documentation for Outpatient Services Policy (formerly HIM.COD.002)  
Applies to diagnostic and procedural coding and reporting of the technical component of outpatient services provided in facilities to ensure minimal variation in coding practices and the accuracy, integrity and quality of patient data and improve the quality of the documentation within the body of the medical record to support code assignment.

REGS.COD.003 Coding References and Tools Policy (formerly HIM.COD.003)  
Ensures that quality coding reference materials and tools are purchased, maintained and accessible to all coding personnel, in a consistent and timely manner. Identifies minimum required reference materials and approved, but not required, materials.

REGS.COD.004 Coding Help Line Policy (formerly HIM.COD.004)  
Provides guidelines for using the 3M Nosology Coding Help Line to provide consistent answers and advice for questions related to ICD-10-CM/CPS and CPT code assignments and DRG/APC assignments. Ensures that the 3M Nosology Coding Help Line is available to all acute medical/surgical facilities with 3M Encoder software to provide quality advice for complete, accurate and consistent coding.

REGS.COD.005 Coding Orientation and Training Policy (formerly HIM.COD.005)  
Establishes mandatory orientation and training to orient all new coding personnel to Company and facility coding policies and procedures, tools and resources, and education and training programs. Requires that completion and documentation of coding education and training requirements be met within 90 days of employment or transfer into a coding position and must be entered in the HealthStream Learning Center (HLC).

REGS.COD.006 Coding Continuing Education Requirements Policy (formerly HIM.COD.006)  
Ensures that all personnel involved in the performance of final coding or formalized auditing of coding processes are aware of coding guidelines and coding guideline changes, which may impact complete, accurate and consistent coding. Establishes that each person involved in the performance of coding or formalized auditing of coding processes must complete a minimum set of required training hours, per calendar year, as defined in the policy. Provides guidance about training tracking and procedures for when training is not completed in a timely manner.

REGS.COD.007 HIM/HSC: Reimbursement of Professional Examination Fee to Obtain Credentials Policy (formerly HIM: Reimbursement of Professional Examination Fee to Obtain Credentials Policy, HIM.COD.007)  
Encourages all individuals involved in the coding process and other health information management related functions to pursue and obtain credentials. Establishes that the Company will reimburse the examination fee for a license or credential examination that has been successfully completed related to the health information management functions, including but not limited to Certified Coding Specialist, Certified Professional Coder, Certified Professional Coder-Hospital, Registered Health Information Technician, Registered Health Information Administrator, Certified Coding Specialist-Physician Office and Certified Coding Associate.

REGS.COD.008 Coding: Additional Compensation Plans Policy (formerly HIM.COD.008. This policy was **retired** effective September 9, 2015 and **reinstated** effective May 1, 2019.)  
Ensures that only approved HCA Healthcare Incentive Pay Criteria related to Coding or Documentation Improvement are used for any employee involved in the performance or

management of hospital coding, hospital coding reviews and/or documentation improvement processes. Also ensures non-approved criteria as detailed in the policy are not used in coding or documentation incentive pay plans.

**REGS.COD.009 Prohibition of Contingency-Based Coding Arrangements Policy (formerly HIM.COD.009)**

Ensures that all external coding consulting companies/personnel are **not** retained via a contingency-based contractual arrangement for the purpose of performing or auditing coding processes including auditing of Uniform Hospital Discharge Data Set (UHDDS) data, UB04/CMS 1500 data and other data directly or indirectly impacting coding, reimbursement and/or billing. Requires exceptions be approved in writing by the SVP and Chief Ethics and Compliance Officer prior to offering or accepting an agreement.

**REGS.COD.010 Coding Documentation for Skilled Nursing Facilities/Units Policy (formerly HIM.COD.010) **RETIRED****

This policy was **retired** effective February 29, 2012. The Coding Documentation for Inpatient Services Policy (REGS.COD.001) includes guidance previously in this policy.

**REGS.COD.011 Certified External Vendors for Coding Reviews and Related Education Policy (formerly HIM.COD.011) **RETIRED****

This policy was **retired** effective November 3, 2009. The External Coding Vendors for Coding Services, Reviews and Related Education Policy (REGS.COD.017) includes guidance previously in this policy.

**REGS.COD.012 Query Documentation for Inpatient Services Policy (formerly HIM.COD.012) **RETIRED****

This policy was **retired** effective October 1, 2010. The Query Documentation for Clinical Documentation Improvement (CDI) & Coding – Compliance Requirements Policy (REGS.DOC.002) includes guidance previously in this policy.

**REGS.COD.013 Coding Documentation for Rehabilitation Facilities/Units Policy (formerly HIM.COD.013)**

Establishes a process to improve the accuracy, integrity and quality of patient data, ensure minimal variation in coding practices, and improve the quality of the physician documentation within the body of the medical record to support code assignments.

**REGS.COD.014 Preferred Contract Coding Vendors for Coding Services Policy (formerly HIM.COD.014) **RETIRED****

This policy was **retired** effective November 3, 2009. The External Coding Vendors for Coding Services, Reviews and Related Education Policy (REGS.COD.017) includes guidance previously in this policy.

**REGS.COD.015 Outpatient Services and Medicare Three-Day Window Policy (formerly HIM.GEN.001) **RETIRED****

This policy was **retired** effective December 1, 2007. The Outpatient Services and Medicare Three Day Window Policy (REGS.GEN.009) includes guidance previously in this policy.

REGS.COD.016 Inpatient Coding Quality Monitoring and Benchmark Analysis Policy **RETIRED**  
This policy was **retired** effective April 15, 2013. The Inpatient and Outpatient Coding Compliance Monitoring and Auditing Policy (REGS.COD.018) replaces this policy.

REGS.COD.017 External Coding Vendors for Coding Services, Reviews and Related Education Policy

Ensures that all ICD-10-CM/PCS/CPT coding and coding review services of medical records for outpatient and inpatient visits and education related to such services performed by external vendors are compliant with official coding guidelines, Company coding policies, and other regulatory requirements.

REGS.COD.018 Inpatient and Outpatient Coding Compliance Monitoring and Auditing Policy  
Establishes a company-wide standardized coding compliance monitoring process to reduce variances in coding practices and ensure compliance with Official Coding Guidelines. Outlines the requirements for validating the coding accuracy (e.g., ICD-10-CM, CPT, modifiers) and various types of inpatient reimbursement methodologies (e.g., MSDRG, APRDRG, etc.) for hospitals inpatients and outpatients.

REGS.DOC.001 Clinical Documentation Improvement (CDI) – Implementation Requirements Policy (formerly Documentation Improvement (DI) – Compliance Requirements)

Addresses the required processes that should be followed for implementing, and/or maintaining a Clinical Documentation Improvement (CDI) Program that appropriately identifies the diagnoses, conditions and/or procedures that are representative of the patient's severity of illness, risk of mortality, and resource consumption during an inpatient hospitalization.

REGS.DOC.002 Query Documentation for Clinical Documentation Improvement (CDI) & Coding – Compliance Requirements Policy

Establishes processes to clarify documentation regarding diagnosis, conditions and/or procedures that are representative of the patient's severity of illness, risk of mortality, and resource consumption during an inpatient hospitalization. It also defines when a query will be initiated and outlines the appropriate query processes to be utilized.

REGS.DOC.003 CDI Orientation and Training Policy

Orients all new Clinical Documentation Improvement (CDI) personnel to Company and facility CDI policies and procedures, tools and resources, and education and training programs.

REGS.DOC.004 CDI Continuing Education Requirements Policy

Ensures that all personnel involved in the performance of the Clinical Documentation Improvement (CDI) function are aware of CDI query guidelines, policies, procedures and applicable coding guidelines which may impact the CDI process.

REGS.GEN.001 Billing Monitoring Policy (formerly GOS.GEN.001) **RETIRED**

This policy was **retired** effective February 1, 2017.

REGS.GEN.002 Medicare – Medical Necessity Policy (formerly GOS.GEN.002) **RETIRED**

This policy was **retired** effective October 11, 2010. The Medicare – National and Local Coverage Determinations Policy (REGS.GEN.011) includes guidance previously in this policy.



REGS.GEN.003 Advance Beneficiary Notice of Non-coverage – Outpatient Services Policy  
(formerly GOS.GEN.003)

Outlines the use of the mandatory Advance Beneficiary Notice of Non-coverage (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 Policy (formerly GOS.GEN.004)

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.

GOS.GEN.005 Standing Orders Policy **RETIRED**

This policy was **retired** effective August 28, 2001. The Orders for Outpatient Tests and Services Policy (REGS.GEN.004, formerly GOS.GEN.004) includes guidance previously in this policy.

GOS.GEN.006 Critical Pathway Order Sets Policy **RETIRED**

This policy was **retired** effective August 28, 2001. The Orders for Outpatient Tests and Services Policy (REGS.GEN.004, formerly GOS.GEN.004) includes guidance previously in this policy.

REGS.GEN.007 Billing Continuing Education Requirements Policy (formerly GOS.GEN.007)

Ensures that all personnel involved in billing and/or billing related services for Federal healthcare programs are aware of billing guidelines and regulatory changes, which may impact complete, accurate and consistent billing.

REGS.GEN.008 Hospital Evaluation and Management Services Policy (formerly GOS.GEN.008)

Mandates that all hospitals paid under the Medicare Outpatient Prospective Payment System follow the HCA Healthcare Evaluation and Management (E/M) Standards and assign E/M services in accordance with the HCA Healthcare E/M Standards. Use of the HCA Healthcare E/M Standards for E/M assignment is mandatory; however, payer specific billing guidelines should be followed.

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

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 Policy

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 Policy

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.GEN.012 Refunds for Medically Unnecessary Services for Federal Payers Policy

This policy specifies a process for making refunds to federally funded payers for services that are determined to be medically unnecessary. After a claim has been paid, when a determination has been made that a service provided to a patient is not medically necessary, the appropriate refund will be made to any federally-funded payer. A written summary of the services determined to be medically unnecessary will be forwarded to the Corporate Regulatory Compliance Support (REGS) department.

REGS.GEN.013 Responding to Governmental Request for Claims Reviews or Surveys Policy

Establishes a consistent process for handling external claim reviews and/or surveys conducted by a governmental entity or its agent. The facility's legal operations counsel should immediately be notified and sent a copy of any request or subpoena from the Department of Justice.

REGS.GEN.014 Medicare Order Form for Patient Status Policy

Requires that facilities obtain appropriate patient status orders and required physician documentation for Medicare Fee-for-Service and Medicare Advantage inpatient admissions. To follow appropriate procedures to ensure such orders and documentation are obtained.

REGS.GEN.015 Correction of Errors Related to Federal and State Healthcare Program FFS Reimbursement Policy

This policy establishes a process to (1) report and return identified and quantified overpayments from Federal healthcare programs, and (2) collect underpayments due to the Company from Federal healthcare programs.

REGS.HHA.001 Advance Beneficiary Notice of Noncoverage – Home Health and Hospice Services Policy

Outlines the use of the mandatory Advance Beneficiary Notice of Noncoverage (ABN) for Home Health and Hospice 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 Home Health and Hospice 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.HHA.002 Responding to Governmental Requests for Claims Reviews or Surveys for Home Health or Hospice Agencies Policy

This policy details responsibilities, procedures and requirements for responding to requests from government entities.

REGS.HHA.003 Correction of Errors Related to Federal and State Healthcare Program FFS for Home Health and Hospice Agencies Policy **RETIRED**

This policy was **retired** effective January 1, 2025. Establishes a process for Home Health and Hospice Agencies to (1) report and return identified and quantified overpayments from Federal healthcare programs; and (2) collect underpayments due to the Company from Federal healthcare programs.

REGS.HHA.004 Medicare – National and Local Coverage Determinations for Home Health and Hospice Services Policy

This policy provides definitions for NCDs, LCDs and LCAs. This policy outlines the responsibilities and processes to facilitate compliance in addition to the clinical and financial implications.

GOS.LAB.001 Calculated Laboratory Tests Policy **RETIRED**

This policy was **retired** effective August 28, 2001. The Maintenance of Company Standard Laboratory Chargemaster Policy (REGS.LAB.025, formerly GOS.LAB.025) supersedes this policy.

REGS.LAB.002 Hematology Procedures Policy (formerly GOS.LAB.002) **RETIRED**

This policy was **retired** effective May 1, 2017. The BILLING – Hematology Procedures, Urinalysis Procedures, and Organ or Disease-Orientated Panels Policy (REGS.LAB.026) includes guidance previously in this policy.

REGS.LAB.003 Urinalysis Procedures Policy (formerly GOS.LAB.003) **RETIRED**

This policy was **retired** effective May 1, 2017. The BILLING – Hematology Procedures, Urinalysis Procedures, and Organ or Disease-Orientated Panels Policy (REGS.LAB.026) includes guidance previously in this policy.

REGS.LAB.004 Organ and Disease Panels Policy (formerly GOS.LAB.004) **RETIRED**

This policy was **retired** effective May 1, 2017. The BILLING – Hematology Procedures, Urinalysis Procedures, and Organ or Disease-Orientated Panels Policy (REGS.LAB.026) includes guidance previously in this policy.

GOS.LAB.005 Handling Charges Policy **RETIRED**

This policy was **retired** effective August 28, 2001. The Billing – Stat, Call Back, Stand-by and Handling Charges Policy (REGS.BILL.006, formerly GOS.BILL.006) includes guidance previously in this policy.

REGS.LAB.006 BILLING – Outpatient Specimen Collection Policy (formerly GOS.LAB.006)

Establishes guidelines for charging and billing specimen collection fees in accordance with the Medicare, Medicaid, and other federally-funded payer requirements. When performed by laboratory staff or other hospital 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, per episode of care regardless of the number of specimens obtained.

REGS.LAB.007 BILLING – Custom Profiles Policy (formerly GOS.LAB.007)

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 Policy (formerly GOS.LAB.009)  
Establishes guidelines for billing clinical laboratory tests referred to other laboratories in accordance with CMS guidelines.

REGS.LAB.010 Laboratory – Reflex Tests Policy (formerly GOS.LAB.010)  
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 provided to the physician initially, then every two years during the re-credentialing process.

GOS.LAB.013 Unlisted Laboratory Procedure Codes Policy **RETIRED**  
This policy was **retired** effective August 28, 2001. The Maintenance of Company Standard Laboratory Chargemaster Policy (REGS.LAB.025, formerly GOS.LAB.025) supersedes this policy.

REGS.LAB.015 Technical Component of Anatomical Pathology Services for Inpatients and Outpatients Policy (formerly GOS.LAB.015) **RETIRED**  
This policy was **retired** effective August 4, 2012, because the "grandfathering" provision that enabled the independent laboratory or pathologist to separately bill the technical component of anatomical pathology services expired June 30, 2012.

GOS.LAB.016 Laboratory Patient Records Policy **RETIRED**  
This policy was **retired** effective June 19, 2001. Guidance regarding laboratory patient records is in the Company's Records Management Policy, EC.014.

REGS.LAB.020 Laboratory Services for Skilled Nursing Facilities Policy (formerly GOS.LAB.020) **RETIRED**  
The policy was **retired** effective November 1, 2006. Laboratory services are included as a part of Skilled Nursing Facility Consolidated Billing. The overall rules for SNF CB apply to laboratory services.

REGS.LAB.023 Laboratory – Client Billing Practices Policy (formerly Laboratory – Marketing Practices Policy and GOS.LAB.023)  
Establishes guidelines for the billing of clinical laboratory services to Clients (as appropriate) in a compliant manner.

REGS.LAB.025 Maintenance of Company Standard Laboratory Chargemaster Policy (formerly GOS.LAB.025)  
Defines the procedures for updating and maintaining the Company Standard Laboratory Chargemaster and describes maintenance responsibilities of Regulatory Compliance Support, Company-affiliated hospitals and Shared Services Centers.

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.

REGS.OSG.001 Coding Documentation for Non-Hospital Entities Policy (formerly Coding Documentation for Outpatient Services Group Entities, GOS.OSG.001 and HIM.PHY.001)  
Ensures minimal variation in coding practices and the accuracy, integrity and quality of patient data, and improves the quality of the documentation within the body of the medical record to support code assignment.

REGS.OSG.002 Advance Beneficiary Notice of Non-Coverage for Physician Professional Services and Non-Hospital Entities Policy  
Outlines the use of the Advance Beneficiary Notice of Non-Coverage (ABN) for outpatient services not covered by Medicare fee-for-service for physician professional services and non-hospital entities.

HIM.PHY.002 Tracking Claims Denials for Co-Owned Professional Services Policy **RETIRED**  
This policy was **retired** effective December 8, 2005.

REGS.OSG.003 Coding References and Tools for Non-Hospital Entities Policy (formerly Coding References and Tools for Outpatient Services Group Entities, GOS.OSG.003 and HIM.PHY.003)  
Ensures that quality coding reference materials and tools are purchased, maintained and accessible to all coding personnel in a consistent and timely manner. REGS will approve and provide a listing of required reference tools and materials.

REGS.OSG.004 Coding and Billing Helpline for Non-Hospital Entities Policy (formerly Coding and Billing Helpline for Outpatient Services Group Entities Performing 1500 Billing and formerly Coding and Billing Helpline for Outpatient Services Group Entities, GOS.OSG.04 and HIM.PHY.004)  
Provides quality advice for complete, accurate and consistent coding and billing related to ICD-10-CM, CPT and HCPCS Level II code assignments for federally funded programs. The policy requires that Coding and Billing Helplines be utilized to provide consistent answers and/or advice regarding coding and billing questions.

REGS.OSG.005 Coding Orientation and Training for Non-Hospital Entities Policy (formerly Coding Orientation and Training for Outpatient Services Group Entities, GOS.OSG.005 and HIM.PHY.005)  
Requires orientation of all personnel responsible for performing, supervising or monitoring coding to the Company's coding policies and procedures, tools and resources, and education and training programs.

REGS.OSG.006 Coding Continuing Education Requirements for Non-Hospital Entities Policy (formerly Coding Continuing Education Requirements for Outpatient Services Group Entities, GOS.OSG.006 and HIM.PHY.006)  
Ensures that all personnel involved in the performance of coding or formalized auditing of coding processes are aware of coding guidelines and coding guideline changes, which may impact complete, accurate and consistent coding. Each person involved in

the performance of coding or formalized auditing of coding processes must complete a required minimum of Coding Education hours per calendar year.

**REGS.OSG.007 Medicare – National and Local Coverage Determinations for Physician Professional Services and Non-Hospital Entities Policy**

Defines the requirements for complying with Medicare's National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) for physician professional services and Non-Hospital entities.

**REGS.OSG.008 Coding: Additional Compensation Plans for Coding Services Submitted on 1500 Claim Forms Policy** (formerly GOS.OSG.008 and HIM.PHY.008)

Ensures that Coding Incentive and Bonus Pay Plans are **NOT** used for colleagues involved in the performance or auditing of coding processes for Non-Hospital entities (including Freestanding Ambulatory Surgery Centers, and Physician Practices) or those performing or auditing the coding of any services submitted on CMS 1500 claim forms. Representations by healthcare providers employed by Non-Hospital entities, as to the services provided to patients (including representations as to the level of service, when a level must be designated) are not considered to constitute coding for the purposes of this policy.

**REGS.OSG.009 Prohibition of Contingency Based Coding Arrangements for Non-Hospital Entities Policy** (formerly Prohibition of Contingency-Based Coding Arrangements for Outpatient Services Group Entities, GOS.OSG.009 and HIM.PHY.009)

Ensures that all external coding consulting companies/personnel are **NOT** retained via a contingency-based contractual arrangement for the purpose of performing or auditing coding processes. Unless approved in writing by the SVP and Chief Ethics and Compliance Officer, contingency-based contractual arrangements are not acceptable for use within the Company.

**REGS.OSG.010 Physician Supervision Requirements for Diagnostic Tests Performed in Freestanding Entities Policy** (formerly GOS.OSG.010)

Outlines physician supervision and oversight requirements for OSG entities such as an Independent Diagnostic Testing Facility (IDTF) or Physician Clinic/Group Practice. Does not apply to Ambulatory Surgery Centers. According to CMS rules, diagnostic tests must be furnished under the appropriate level of supervision by a physician.

**REGS.OSG.011 Certified External Vendors for Coding Reviews and Related Education for Non-Hospital Entities Policy** (formerly Certified External Vendors for Coding Reviews and Related Education for Outpatient Services Group Entities, GOS.OSG.011 and HIM.PHY.011)

Ensures that all external ICD-10-CM and CPT coding reviews of medical records for Non-Hospital entities and education related to such reviews are compliant with official coding guidelines, Company coding policies, and other regulatory requirements. Such reviews performed by external vendors should only be completed by vendors who have been certified to meet the quality and business practice standards outlined in this policy. Certification of vendors is the responsibility of Regs.

**REGS.OSG.012 Responding to Governmental Requests for Non-Hospital Entities Claims Reviews or Surveys Policy**

Establishes a consistent process for handling external claim reviews, Comparative Billing Reports (CBRs) and/or surveys conducted by a governmental entity or its agent.

The notification of a claim review can originate from, but is not limited to, the Office of Inspector General (OIG), Unified Program Integrity Contractor (UPIC), the Centers for Medicare & Medicaid Services (CMS) and its contractors, a State Medicaid Agency, or a company contracted by the governmental entity to perform the review. The non-hospital entity's legal operations counsel should immediately be notified and sent a copy of any request or subpoena from the Department of Justice.

**REGS.OSG.BILL.001 Billing Guidelines for Orders for Outpatient Tests and Services for Non-Hospital Entities Policy** (formerly Billing Guidelines for Orders for Outpatient Tests and Services for Outpatient Services Group Entities)

Establishes billing guidelines outlining the documentation required for complete non-hospital outpatient test(s) and service orders in order to bill in accordance with Medicare, Medicaid and other federally-funded payer guidelines. Orders for outpatient tests and services are valid for billing provided they are documented and include the data elements as defined in the policy.

**REGS.PROF.006 Provider Coding/Billing Continuing Education Requirements for Professional Services Policy**

Establishes a requirement that new PSG Physicians and APPs must complete a minimum of two (2) hours of coding and documentation education within sixty (60) days of employment. Established PSG Physicians and APPs must complete annual education as assigned.

**Reimbursement (RB)**

**RB.001 Reimbursement Manual Policy**

Establishes guidelines to refine, maintain and publish a Reimbursement Manual that will include corporate and departmental policies and procedures to be utilized by all reimbursement staff.

**RB.002 Standardized Workpaper Package with Instructions Policy**

Establishes guidelines to refine, maintain and update a standardized workpaper package with instructions to use when preparing the filed cost report. Establishes that the reimbursement department will provide all facilities with a standardized workpaper package with instructions to be utilized in preparing the filed cost report.

**RB.003 Review of Cost Report Policy**

Ensures that the filed cost report has been reviewed for accurate presentation of the facility's operations, compliance with applicable regulations, and adequate documentation to support the costs claimed. Requires the Reporting Director to review the filed cost report in detail for compliance with applicable government regulations, and the Division Director to review the filed cost report to ensure it accurately reports the financial operations of the facility and the services provided to program beneficiaries.

**RB.004 Identification of Non-Allowable Costs Policy**

Ensures that non-allowable costs are not claimed for reimbursement in the filed cost reports. Requires that costs which are non-allowable, and costs not supported by verifiable and auditable data, must not be claimed for reimbursement in the filed cost reports.

**RB.005 Adequate Documentation Policy**

Ensures that cost reports are filed based on adequate documentation that is auditable and verifiable. Requires that all data included in filed cost reports must be based on auditable, verifiable, and adequate documentation.

**RB.006 Protested Items Policy**

Ensures that all reimbursement personnel utilize the protest lines of the cost report to protect appeal rights when claiming costs on the cost report that are contrary to clearly expressed Program policy. Requires that all items claimed in the cost report to protect appeal rights that are contrary to clearly expressed Program policy (law, regulation CMS publications) and/or past audit adjustments where the Company does not agree with the Program's interpretation of the policy must be disclosed to the Fiscal Intermediary/Medicare Administrative Contractor in the cost report's transmittal letter and must be reported on the protest line of the settlement worksheet.

**RB.007 Submission of the Medicare Cost Report Policy**

Ensures that the Facility CEO or CFO understands the representations made in the cost report.

**RB.008 Disclosure Procedure Policy**

Ensures that the Medicare cost reports are filed with complete and adequate disclosure. Requires that a transmittal letter accompany all filed Medicare cost reports to notify the Fiscal Intermediary/Medicare Administrative Contractor (FI/MAC) of the following issues:

1. Medicare reserves for financial statement purposes
2. Changes in cost reporting from the prior year
3. New issues or complex transactions for current cost reporting period
4. Protested Items (Supplemental Schedule A)

**RB.009 Reporting of Cost Report Overpayments Policy (formerly Error in Reporting)**

Requires that the Medicare Administrative Contractor and/or the appropriate fiscal intermediary will be notified in writing, within 60 days of the date of identification of an overpayment discovered subsequent to filing a cost report for all applicable payers (e.g., Medicare, Medicaid, or TRICARE), regardless of the financial impact to the provider. If the overpayment is identified within 6 years of the overpayment occurring, the applicable refund will accompany the notification.

**RB.010 Fiscal Intermediary/Medicare Administrative Contractor Audits Policy**

Ensures that the coordination and finalization of the Fiscal Intermediary/Medicare Administrative Audit (FI/MAC) audit is clearly defined, thorough and conducted in a professional manner. Provides that the appropriate Reimbursement Department personnel, in conjunction with the FI/MAC, are responsible for coordinating, monitoring, and resolving FI/MAC audit issues. Requires that responses to FI/MAC requests and resolutions to audit disagreements must be provided prior to the issuance of the Notice of Program Reimbursement.

**RB.011 Subsequent Monitoring–Departmental Self Review/Peer Review Policy**

Assures that Reimbursement Department personnel are effectively adhering to Departmental and Company policies and procedures. Requires the Reimbursement Department Senior Management and Group Directors to administer a peer review to



provide assurance that reimbursement personnel are adhering to the reimbursement policies and procedures.

**RB.012 Monitoring – External and Independent Departmental Review Policy **RETIRED****

This policy was **retired** effective December 7, 1999.

**RB.013 Arrangements with External Consultants Policy**

Requires that external reimbursement consultants are being appropriately utilized and compensated for services provided related to Medicare and any other third-party payer reimbursement activities.

**RB.014 Education and Training Policy**

Requires that Reimbursement Department personnel receive effective and timely education on Federal and State statutes, regulations and guidelines, and Corporate policies. Also requires that an education curriculum be developed, maintained and updated to meet the needs of all Company professional staff involved in third-party payer reimbursement activities.

**RB.015 Reserve Cost Reports Policy **RETIRED****

This policy was **retired** effective May 23, 2006.

**RB.016 Requirements for Providers/Suppliers to Establish and Maintain the Medicare Enrollment Application (CMS-855) Policy**

Establishes protocols for the completion and maintenance of the Medicare Enrollment Application (CMS-855) which is the mechanism used by CMS to gather information on providers and suppliers. All Company-affiliated facilities that bill, or have bills submitted on their behalf, for Medicare services must adhere to regulatory requirements for enrollment, periodic resubmission and certification of enrollment information for revalidation, timely reporting of updates and changes to enrollment information.

**Risk & Insurance – See Legal for EMTALA Policies (LL.EM)**

**Safety and Security (SS) – See Information Protection and Security – Physical Security (IP.PS)**

**Treasury (TRE)**

**TRE.001 Medical Staff Funds Policy**

Establishes parameters for establishing and administering accounts for Medical Staff funds. If a facility Medical Staff wishes to establish an account for their funds, the preferable method is for the Medical Staff to establish an account in their own name and with their own Taxpayer Identification Number (TIN). However, a facility may establish an account on the Medical Staff's behalf, provided it follows the procedures in this policy.

**TRE.002 Non-Facility Owned Funds Policy**

Establishes internal control guidelines for employee involvement in non-facility owned funds.

**TRE.003 Vendor Profile Management Policy**

This policy outlines the data requirements that establish and maintain vendor information utilized for payment processing by the Company while ensuring completeness and accuracy of vendor profile data, particularly focused on avoiding fraudulent or fictitious vendor payments.

