	Ethics & Compliance Department		
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CORRESPONDENCE WITH MEDICARE AND MEDICAID CARRIERS

SCOPE

Applies to all Envision clinicians and teammates who may be involved in correspondence with Medicare and Medicaid carriers. For purposes of this policy, all references to "clinician" or "teammate" include temporary, part-time and full-time employees, independent contractors, officers and directors.

PURPOSE

Envision Healthcare Operating, Inc. and its subsidiaries and affiliates ("Envision" or "the Company") has adopted this Correspondence with Medicare and Medicaid Carriers Policy to provide documented guidelines for Envision clinicians and teammates to consult when corresponding with Medicare, Medicaid, Medicaid Carrier, Center for Medicare/Medicaid Services (CMS), Department of Health and Human Services ("HHS"), Department of Justice ("DOJ"), and any other government agency.

POLICY/PROCEDURE

Company clinicians and teammates must consult the guidelines listed below prior to corresponding with government payors.

Non-Routine Correspondence

The Ethics & Compliance Department and/or the Legal Department must approve all non-routine correspondence with Medicare, Medicaid, TRICARE, and other government payor programs. Non-routine correspondence refers to letters discussing Company's position, question, or opinion on a particular government rule, regulation, policy, position, or interpretation. The Company strives to maintain a consistent position when working with government agencies that administer, govern, and enforce these programs.

The correspondence should be forwarded to the Ethics & Compliance Department and/or the Legal Department for review and approval prior to distribution. Correspondence will be

reviewed in a timely manner to meet government deadlines for response. The Company will maintain a record of all correspondence.

Routine Correspondence

Routine correspondence refers to routine calls or meetings, typically with Medicare and Medicaid carriers, addressing or clarifying the coding and billing procedure for a specific item. These calls are made by a representative of the Company's Revenue Cycle Management team during the normal course of conducting daily business. An example of this would be a representative asking for clarification on the appropriate HCPCS code when billing the Texas Medicaid program for rhythm strips.

Any Envision representative that conducts routine correspondence, clarifying the coding and billing procedures with government payors and agencies, should maintain an annual log. This log should include the following:

- Date and time of the call/meeting
- All persons participating in the call/meeting
- Carrier name (MAC, state Medicaid, etc.)
- Nature or question(s) of the call/meeting
- Answer or response from the government representative
- Result or next step by the billing entity
- Call reference number (if applicable)

Mention of overpayment, refund obligation, fraud, waste or abuse, medical necessity denial trends must be escalated promptly to the Ethics & Compliance Department.

The clinician's or teammate's manager should maintain these annual logs for a period of seven (7) years. These logs are necessary to support billing and coding practices recommended by government agencies to our billing entities.

POLICY REVIEW

The Ethics & Compliance Department will review and update this Policy, when necessary, in the normal course of its review of the Company's Ethics & Compliance Program.