



Policies and Procedures

**Ike Pono Medical Billing Hawaii
Policy and Procedure Guide**

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Standards of Conduct

Mission, Goals and Ethical Principles

Ike Pono Medical Billing Hawaii strives to maintain the highest ethical standards in the industry of professional medical billing. We endorse the compliance efforts of the OIG and have established an internal compliance program that employees readily understand. Our standards of conduct reflect our commitment to the highest quality health data submission as evidenced by our accuracy, reliability, timeliness and validity.

The Compliance Manager works with the management to write and adopt standards; respond appropriately to complaints and other information concerning illegal or unethical activity (suspected or known); investigate promptly all such complaints and information and take appropriate corrective action; ensure that all staff and independent contractors/agents have been checked against the Office of Inspector General's List of Excluded Individuals and Entities; and report to management on compliance program progress.

The management team will identify risk areas; write policies and procedures; implement policies and procedures; monitor audits and investigations both internal and external; analyze and develop new strategies as needed; and periodically review compliance policies and procedures for adequacy.

Purpose

The Standards of Conduct of Ike Pono Medical Billing Hawaii ensure compliance with healthcare fraud and abuse laws. IPMBH is committed to complying with all state and federal mandates governing the operation of healthcare billing companies.

Compliance with Laws and Regulations

- **Accurate Claims Coding and Submission:** Ike Pono Medical Billing Hawaii does not bill for services or items that have not been documented. Due to the lack of access to the client's EHR systems and/or paper documentation, client confirms the completion of such documentation upon entering patient's name on billing' system calendar which serves as a request for billing.

- **Accurate Business Records and Retention:** IPMBH's business records are properly documented and reflect facts regarding all business transactions. In accordance with OIG regulations, records are retained and safely secured in either paper or electronic forms for a period of seven years from the time of service.

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- **Kickback Prohibition:** Ike Pono Medical Billing Hawaii does not provide incentives to attract patients nor do we engage in any other activities that would violate OIG's Anti-Kickback Statutes.

- **Refund of Overpayments:** If Ike Pono Medical Billing Hawaii determines that an overpayment has been made the credit balance will be submitted for refund to the proper party, regardless of whether a refund has been requested.

- **Courtesy Discounts and Waivers of Co-Payments:** IPMBH does not waive or adjust co-payment or deductible obligations of patients, unless instructed to do so by our client, who we believe in good faith will uphold legal standards. Hardship, bad debt, and out-of-network adjustments are to be utilized only when the patient meets the documented requirements for the adjustment and will be used without discrimination.

- **Honesty:** Ike Pono Medical Billing Hawaii will follow ethical business operations and good common sense, promoting a 'best practice' approach. No Ike Pono employee or subcontractor/agent will attempt to mislead government bodies or agencies to influence actions or decisions.

- **Cooperation with Government Investigations:** Ike Pono Medical Billing Hawaii will be cooperative and forthcoming in any government inquiries, including audits, questioning and reviews.

- **Financial Interests:** IPMBH's administrators, employees and subcontractors/agents may not solicit or accept gratuities, favors or bribery that may influence sound and legal business decisions.

- **Confidential Information:** All employees and subcontractors of Ike Pono Medical Billing are required to sign applicable Confidentiality Agreements (employees) and Second Tier Business Associate Agreements (subcontractors/agents) to protect health information handled through business operations. These agreements will be in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Additionally, confidential information about Ike Pono Medical Billing Hawaii's not to be communicated outside of the company by any employee without explicit written authorization of the administration.

Violations of Standards of Conduct

Violations of IPMBH's standards of conduct must be promptly reported to the Compliance Manager. If the Compliance Manager or another administrative member has violated the standards, another manager must be notified.

Confidentiality

General Policy

It is our policy that all internal business of Ike Pono Medical Billing Hawaii is confidential. Confidential information may not be communicated by any employee to the public. All documents and files generated in the course of duty as an employee are the property of our organization and considered business records. All requests for disclosure of business records will be handled in accordance with our policies and procedures. Corrective action will be taken for all violations.

Definitions

Confidential Information: Any information, whether written or verbal, relating to the internal business operations of our organization not available to the public. This includes general business operations, finance records, fee schedules, marketing plans, contractual agreements, client information and billing records.

Procedure

Employees must adhere to the following standards at all times:

- Employees must never discuss information regarding a client or client's patients (including medical and billing records) with anyone other than to carry out job duty functions on behalf of the client.
- Discretion and responsibility are expected and should be exercised by all employees by not disclosing any organizational information about Ike Pono Medical Billing Hawaii.

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Access to Patient Information

General Policy

Access to a patient's billing record must be treated with utmost respect and confidentiality. Access to both paper and electronic medical records should be limited to only those employees for whom the information is necessary for the completion of job duties.

Procedure

- It is the responsibility of the Systems Administrator to manage Ike Pono's computer systems, including all linkages to external systems, so that access to patient health information is not unduly obtained and to ensure compliance with the security standards documented herein.
- It is the responsibility of the Systems Administrator to regularly review the security controls of the billing systems to ensure that they are all functioning properly.
- It is the responsibility of the Systems Administrator to review all audit reports and note any suspicious activity.
- Audit records shall be kept at least six months and custodians shall periodically review them for evidence of violations or system misuse.
- The Systems Administrator must periodically review user access privileges and remove identification codes and passwords from MBA's computer systems when user's no longer require access.
- Access to patient records may be obtained only by those employees who have been specifically authorized by the Compliance Manager.
- Incidents or suspicions of unauthorized access to patient information should be recorded and reported to the Compliance Manager.

Workstations

Rules Governing the Use of Workstations

- The use of MBA's information systems or data for personal business or gain is strictly prohibited.
- Employees are prohibited from unauthorized browsing of patient, personnel, financial, or other records for the purpose of personal curiosity or with the intent of improperly disclosing the information contained in those records.
- Every employee will receive a unique username and password for accessing Ike Pono's computer systems. Employees should use their own username and password when performing their regular job duties.
- Usernames and passwords should not be shared except under special circumstances approved by the Systems Administrator.
- Employees are prohibited from listing their username and password on their monitors, under their keyboards, or in any other obvious location.
- Employees should log out when they are not using the practice management system. Workstations will require a password protected login anytime a workstation is idle for more than 15 minutes.
- Employees are prohibited from leaving their workstation unattended with confidential information displayed on the monitor.
- Employees are prohibited from installing unauthorized or illegally-copied software on any workstations.
- Employees are prohibited from altering or removing any software or data on any of Ike Pono's computer systems, except in the course of performing authorized business functions.
- Employees are prohibited from interfering with the operation of any of Ike Pono's computer systems or using an IPMBH workstation to disrupt any external computer system.

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Claim Generation Process

Procedure

Each employee will assure the following claims processing activities are not participated in:

- Submitting claims for undocumented services (By Confirming Patients on CMD calendar provider confirms that an encounter form has been created and signed by rendering provider)
- Unbundling or up-coding
- Billing for discharge in lieu of transfer
- Improper use of modifiers
- Assumption coding
- Alteration of documentation
- Coding without documentation
- Billing for services provided by unqualified personnel

Information will be received from the client in the following format and manner:

- Thru Collaborate MD Scheduler by changing Appointment Status to CONFIRMED
- On electronic encounter forms via a secure portal or encrypted email

For new patients, a completed encounter form must be received in order to initiate the claims process. A complete form includes:

- All patient demographic information including: name, sex, DOB, SSN, responsible party information, mailing address, and all insurance information.
- Valid CPT4, ASA, or HCPCS codes for all procedures performed.
- Valid ICD10 codes for all documented diagnoses.

Once confirmed encounters have been received, the following steps will be taken to produce claims:

- A charge batch will be created in the appropriate practice management system.
- The patient information will be loaded in the system, if it is not already there.
- The encounter information will be keyed into the charge batch.
- After all of the encounter forms are entered the batch will be posted and will become a permanent part of the billing record.

After a batch is posted, insurance claims are filed and submitted to the insurance in one of the following ways:

- Submitted electronically to a clearinghouse
- Submitted electronically to the carrier
- Printed on a CMS-1500 claim form and mailed to the carrier

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Waivers, Discounts and Financial Hardships

General Policy

Ike Pono Medical Billing Hawaii. does not offer discounts, professional courtesies, or waive co-payments or deductible unless directed to do so by our client, who we believe in good faith will arrive at such a decision in accordance with all applicable laws. Waivers and discounts are strongly discouraged with our clients and are addressed on a case-by-case basis.

Regulatory Requirements

Federal Register Vol. 63 No. 243, December 18, 1998, p. 70143. The OIG issued Compliance Program Guidance for Third Party Medical Billing Companies.

- ‘Billing companies should encourage providers to make a good faith effort to collect co-payments, deductible and non-covered services from federally and privately insured patients. Billing “insurance only” may violate the False Claims Act, the anti-kickback statute, the Civil Monetary Penalties Law, and State laws.’
- ‘Discounts and professional courtesy may not be appropriate unless the total fee is discounted or reduced. In such situations the payer should receive its proportional share of the discount or reduction.’
Federal Register Vol. 59 No. 65, December 19, 1994, p. 373. Publication of OIG Special Fraud Alerts.
- ‘A provider, practitioner, or supplier who routinely waives Medicare copayments or deductibles is misstating its actual charge.’
- ‘When providers, practitioners, or suppliers forgive financial obligations for reasons other than financial hardship of the particular patient, they may be unlawfully inducing that patient to purchase items or service from them.’
- ‘Anyone who furnishes items or services to patients substantially in excess of the needs of such patients can be excluded from Medicare and State healthcare programs.’

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Procedure

IPMBH will continuously work to inform clients of the laws governing balance adjustments. In addition, the following practices will be carried out:

- Clients will be encouraged to make good faith efforts to collect all patient co-payments, deductibles and other amounts due by the patient or responsible party.
- Clients who continually engage in questionable practices will be reported to the Compliance Manager who will evaluate their activities and determine the appropriate steps for resolving the issue or discontinuing services to the client.

Employees will always adhere to the following policies regarding patient balance adjustments:

- Employees are forbidden from writing-off patient co-payments, deductibles, or other insurance-designated patient balances unless directed to do so by the provider.
- Financial hardship adjustments are not routine but should be decided on a case-by-case basis, approved by an account manager, and well documented.
- The following Standard Adjustments are acceptable when performed in accordance with the accompanying written policies:
 - Contractual adjustments
 - Out-of-network adjustments
 - Rebilling fee adjustments
 - Charity adjustments
 - Transfer of balances between accounts or to collections
 - Bad-debt adjustments approved by the provider

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Standard Adjustments

General Policy

Ike Pono Medical Billing Hawaii only adjusts charges in accordance with written policies, which do not violate any applicable laws. Policies regarding charge adjustments are agreed upon with our clients prior to implementation.

Contractual Adjustments

Employees are empowered to adjust charges in accordance with contracts between our clients and payers. The following guidelines must be followed:

- Contractual adjustments should reference the relevant contract.
- Charges are not to be entirely written-off without the authorization of an account manager.
- Charges are not to be reduced below the Medicare allowable for any charge (with the exception of other state or federal programs such as Medicaid, Champus, and Workers Compensation).
- Special circumstances causing an adjustment (such as timely filing) should be indicated in the billing record.

Out of Network Adjustments

IPMBH recognizes that our clients are unable to contract with every insurer. Some clients feel that patients who have coverage through a non-contracted payer should not be denied the reduced allowable that contracted payers are afforded. For these providers we have recommended a fixed out-of-network allowable to be used for all non-contracted payers. In an effort to make the allowable fair we use it in accordance with the following guidelines:

- To avoid violating Medicare regulations the allowed amount must be greater than the Medicare allowable.
- To avoid discrimination the allowed amount must be applied the same for all out-of network payers.
- To avoid violating the Stark II laws the allowable can't be used as an incentive or kickback to attract patients.
- To avoid conflicts with existing contracts the adjustment can't be used along with, or in place of, an existing contractual adjustment.

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Charity Adjustments

IPMBH is aware that our clients participate in programs through which medical services are provided in support of a charitable cause (Save the Children, Breast & Cervical Program, etc.). The charge for these services will be adjusted to reflect any terms agreed upon by the provider.

Collections Adjustments

Employees are expected to make every effort to get a balance paid before transferring the balance to collections. When all efforts to collect a balance have been exhausted employees are authorized to transfer balances to collections in accordance with the following guidelines:

- Providers must authorize the account to be sent to collections either on a case-by-case basis or through a written policy.
- Neither clients nor employees are allowed to discriminate. The same procedures and criteria should be used for all patients when making the determination to send an account to collections.

Bad Debt Adjustments

Employees are expected to make every effort to get a balance paid before making a bad debt adjustment. When all efforts to collect a balance have been exhausted employees are authorized to make bad debt adjustments in accordance with the following guidelines:

- Rebilling fees can be negotiated, reduced, or written-off entirely to bad debt.
- Balances of \$25.00 or less can be written-off to bad debt.
- Balances greater than \$25.00 can only be written-off if directed to do so by the provider.
- Neither clients nor employees are allowed to discriminate. The same procedures and criteria should be used for all patients when making the determination to write-off a balance to bad debt.

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Bankruptcy

General Policy

Billing staff are expected to adhere to all legal requirements regarding the handling of bankruptcy accounts. The following guidelines should always be followed:

- When a notice of bankruptcy filing is received all pertinent information should be noted on the patient account.
- On the Misys Tiger system the Bill Cycle and Patient Type should indicate a Bankruptcy status and an alert note should be added to warn schedulers.
- The patient should not receive calls or letters while a bankruptcy is pending.
- If a Discharge is received any balances incurred prior to the bankruptcy filing date should be written off.
- If a Dismissal is received the notice should be filed in an EOB file, the account should be noted, and the appropriate account status should be restored.

Mail Return Accounts

General Policy

When an account statement or other patient correspondence is returned by the post office an attempt should be made to contact the patient by phone. If the attempt is successful, the patient account should be corrected, and the correspondence should be re-mailed. If the billing specialist is unable to resolve the address problem the following steps should be taken:

- The old address should be placed in the notes on the account and an alert note should be created to warn schedulers.
- The Bill Cycle and Patient Type should indicate a Mail Return status.
- The undelivered mail should be forwarded to the client in a final attempt to attain corrected information. If they are unable to resolve the problem they must make a determination regarding the handling of the debt.

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Bad Debt and Collections

General Policy

Billing staff will routinely produce account aging reports to identify uncollected balances and/or bad debt. Bad debt balances over \$25.00 will be reported to the client for determination about future action.

Definitions

Bad Debt: Remaining balance due on an account after an insurer and/or individual has been billed with no response in payment.

Internal Collections: At least two formal letters are sent and two phone calls are made to the responsible party when an account remains past due. If those actions do not produce a response, further action will be taken according to conditions set forth by the client.

External Collections: After all resources have been exhausted, remaining account balances may be turned over to an outside collection agency at the client's discretion.

Standard Adjustments: Amounts added or subtracted to the account balance to reflect charge corrections, allowable amounts, or payment arrangements.

Write-Off: Amount subtracted from an account after the debt has either been either forgiven by the provider or transferred to external collections.

Procedure

Billing staff will follow these guidelines when handling bad-debt accounts:

- Routine monthly aging reports are run to identify and make efforts to collect outstanding balances.
- Accounts with uncollected balances greater than 90 days will enter the internal collections process, which includes at least two phone calls as well as formal letters at 90 days old and again at 120 days.
- If no response is received the account ledger is printed out and forwarded to the client to determine if it is appropriate to turn over to external collections.
- All notes and outcomes are documented on the patient account.

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Identifying and Reporting Credit Balances

General Policy

Billing staff will track overpayments and regularly report them to our clients for refunding. Ike Pono Medical Billing Hawaii will monitor routine aging reports to identify overpayments that were overlooked when originally applied. All overpayments will be reported to the client for refund regardless of whether a refund has been requested.

Procedure

All payments will be applied to the patient's account by line item, with the billing staff verifying that the appropriate patient, service date, and procedures were indicated on the payment. Payments that create a credit on any individual line item are considered an overpayment or duplicate payment and must be addressed in accordance with the following guidelines:

- The client is responsible to refund overpayments. Clients who regularly neglect to refund overpayments or delay in doing so are to be reported to the Compliance Manager who will inform the client of their responsibility and the consequences of failing in that regard.
- Overpayments are to be tracked in a log and reported to the client within 30 days of recognition.
- The client will receive a copy of the ledger, a copy of any relevant EOB's, and a clear indication of the appropriate payee and amount of the refund.
- To avoid discrepancy, the payer entitled to the refund will receive a copy of any pertinent EOB or remittance along with the refund issued by our client.
- Once a refund is issued the credit balance on the appropriate account will be adjusted to reflect the refund. A copy of the check and EOB's will be kept on file.
- All notes and outcome will be documented on the patient account.

Patient Rights

- ***Right to Privacy:*** Relevant patient information may only be disclosed to those directly involved in the care of the patient, for the payment of services as authorized by the patient, for the protection of the public health as provided by law, or for any other purposes authorized by the patient or required by law.
- ***Right to Review Information:*** Patients are entitled to know which information about them is in the possession of Ike Pono Medical Billing Hawaii and are entitled to review that information.
- ***Right to Clear and Complete Presentation of Information:*** When requested, information will be presented to the patient in the most complete and understandable format available to us. We will accommodate special requests to the best of our abilities.
- ***Right to Amend and Correct Information:*** Information cannot be deleted, but erroneous information can be marked as such and correct information amended.
- ***Right to Restrict the Use and Disclosure of Specific Information:*** The patient has the right to segment information and block the release of specific information so that only necessary information is shared. It is our responsibility to identify and explain consequences of such blockage.
- ***Right to an Accounting for Disclosures of Information:*** The patient has the right to know which individuals, organizations, and government agencies have authority to access, and have actually gained access to, specific information.
- ***Right to Protection of Information Released to Third Parties:*** Ike Pono Medical Billing Services, Inc requires that third parties also maintain a commitment to protection in order for us to release information to their organization.

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Patient Access to Health Information

General Policy

It is our policy to respond to information requests in a professional and timely manner. We maintain patient information in our billing records that is sometimes needed in addition to medical records contained in our client's charts. When the proper authorization is received and documented the information is disclosed without delay.

Procedure

An individual will be allowed access to pertinent health information from our billing records in accordance with the following guidelines:

- A written request must be received along with a signed authorization from the patient, guardian, or next-of-kin.
- Requests and resulting actions must be noted in the patient's account.
- Requested information must be disclosed to the requesting party within 30 days of authorization.

Patient Amendment to Health Information

General Policy

Ike Pono Medical Billing Hawaii does not respond directly to HIPAA-based requests for amendment of records by individuals. We maintain the information in our billing records in congruence to the records maintained by our clients. Under HIPAA Rule our organization is not required to amend such information as directly requested by the patient.

Definitions

Amendment – To add information to an existing record that either provides additional information, clarifies or corrects existing information, or provides an alternative view with respect to information that we have compiled about a patient.

Procedure

- All individuals requesting amendment should be instructed to contact our client's (their provider's) office.
- If we are informed by our client, in writing, of an amendment to a billing record we will carry out the request without delay.
- All amendments are to be documented within the appropriate account in our billing system.

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Use and Disclosure of Protected Health Information

General Policy

Ike Pono Medical Billing Hawaii is responsible for maintaining and securing health information that is stringently protected by federal law and this duty is taken very seriously. In the course of normal business operations it may become necessary to use or disclose health information under our protection. In such situations it is mandatory that a valid authorization from the patient be provided before any protected health information (PHI) is released, except as provided for by federal regulations. The authorization must have been obtained from the patient, legal guardian, or next-of-kin. It is our policy to fulfill such requests for information within 30 days of receipt of a valid authorization for release.

Procedure

Release of protected health information will occur only within the following guidelines:

- Prior to any disclosure of PHI an Authorization for Release of Information form must be complete and signed by the patient, legal guardian or nextof-kin. The form must contain:
 - Name or other specific identification of the person(s) or class of persons authorized to make the requested use or disclosure, or to whom we may make the requested use or disclosure.
 - Description of the information to be used or disclosed must be indicated and a date range must be specified.
 - Date on which the authorization expires. This is 90 days from the date of the request.
 - Signature of patient, legal guardian or next-of-kin, and date signed.
- If someone other than the patient is signing the authorization form, that individual's relationship to the patient must be stated.
- The authorization form requests the individual to identify the purpose of the disclosure. This is not required but is desirable in order to provide a proper accounting for disclosures.
- When a client requests information contained in the billing record, no written request is required. The requested information will be forwarded to the client within 5 business days.
- If a request is made by an attorney it will be honored only upon receipt of a valid authorization form or court order directing IPMBH to release PHI to the attorney.
- If the request is from an individual to access his/her own information the access will be provided in accordance with our policies on an Individual's Right to Access Health Information.

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De-Identification of Protected Health Information

General Policy

Our policy on Use and Disclosure of Protected Health Information serves as our guidelines as to when it is acceptable to release individually identifiable health information to other persons or organizations. For all other uses and disclosures we require the removal of information that could be used to identify the individual. Employees are required to de-identify individually identifiable PHI by removing the following specified identifying characteristics of the individual or of relatives, employers and household members of the individual:

- Names
- All geographic information below the state level:
 - Street Address
 - City
 - County
 - Precinct
 - Zip Code (Or Equivalent Geocode)
- Month and day for all dates directly related to an individual:
 - Birth Date
 - Admission Date
 - Discharge Date
 - Date of Death
- All ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.
- Telephone numbers.
- Fax numbers.
- E-mail addresses.
- Social Security numbers.
- Medical record numbers.
- Health plan beneficiary numbers.
- Account numbers.
- Certificate/license numbers.
- Vehicle identifiers (license plates/serial numbers).
- Device identifiers and serial numbers.
- Websites (Universal Resource Locators – URLs).
- Internet Protocol (IP) address numbers.
- Biometric identifiers including finger and voice prints.
- Full face photographic images and any comparable images.
- Any other unique identifying number, characteristic, or code.

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General Policy (Continued)

If we have any reason to suspect that, after de-identifying the information, the individual could still be identified, we will take additional reasonable steps to remove such information. If we are unable to adequately de-identify data for a requested purpose, we will either seek written authorization to release the information or will refuse the release. Should we believe we will need to re-identify the information at any time in the future, we may assign a special code to the de-identified information for each individual. This code may not be derived from or related to information about the individual and may not be able to be translated in such a manner as to identify the individual except by persons authorized by IPMBH to do so. No one outside of IPMBH is permitted to disclose the codes or their means of creation. Any such disclosure will constitute a disclosure of protected health information and could be subject to disciplinary action in accordance with our policies.

Procedure

The disclosure of De-Identified Protected Health Information can take place only in accordance with the following policies:

- All employees will be trained in the de-identification process and the importance of de-identifying individually identifiable information except:
 - Uses or disclosures for treatment, payment, or business operations.
 - When disclosure is required by law or other disclosures allowed without authorization.
 - When an authorization for release has been obtained.
 - It is generally the responsibility of each employee to assure that information has been de-identified prior to disclosure.
 - When large quantities of information must be de-identified we may enlist the services of an outside business entity. That entity will be required to enter into our Business Associate Agreement before we release any PHI to them.
- If we are unable to adequately de-identify information for a requested purpose other than as specified above we will either seek written authorization to release the information or refuse release.

Minimum Necessary Information

General Policy

When using or disclosing Protected Health Information (PHI), or when requesting PHI from our client, each employee of Ike Pono Medical Billing Hawaii must make reasonable efforts to

limit the disclosure to the minimum necessary to accomplish the intended purpose of the request. This requirement does not apply to disclosures to a healthcare provider for treatment, uses or disclosures made to the individual, uses or disclosures made pursuant to a signed authorization for release, disclosures made to the Secretary of Health and Human Services, disclosures required by law and uses or disclosures that are required for compliance with the Privacy Rule.

Disclosure for Treatment, Payment or Healthcare Operations

The rules establish that routine and recurring disclosures of PHI can be made for treatment, payment or healthcare operations without specific authorization. For all routine and recurring disclosures minimum necessary determinations should be made. The level of disclosure is restricted based on the determined category.

CATEGORY 1 - Full health information will be provided to routine and recurring requests from these Category 1 sources:

- Healthcare Providers
- Insurers/Health Plans
- Patients
- Family Members Involved In Care
- Workers' Compensation Providers
- Transcription Services

CATEGORY 2 - Minimal necessary information will be provided in the following situations:

- Requests for medical information to determine necessity.
- Sample records for accreditation or audits.
- Records review for protocol adherence.
- Patient information for participation in clinical trials.
- Referral requests and certification.

CATEGORY 3 – Summary data with treatment and/or diagnostic codes will be provided to routine and recurring requests from:

- Practice Management Support Staff
- Clearinghouses

CATEGORY 4 – Demographic data with only minimal reference to treatment or diagnostic information will be provided to routine and recurring requests from:

- Technical Support Staff

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Requests for Information

Federal regulations establish that for routine and recurring requests the responsibility for determining the minimum necessary data falls on the requestor in all situations where data is requested. IPMBH employees must ensure that the minimum necessary evaluation has been made and communicated to IPMBH. In situations where the determination has not been made, and the appropriate category can't be determined by the employee, the determination should be made by the Compliance Manager or another administrator.

Handling of Privacy Complaints

General Policy

It is our policy that Ike Pono Medical Billing Hawaii does not respond directly to HIPAA-based complaints against healthcare providers. Should a complaint be placed against Ike Pono Medical Billing Hawaii it is our policy to investigate the complaint to determine the circumstances surrounding any concerns our clients or their patients may raise regarding privacy. If a patient's privacy rights have been infringed upon in any way, or there is evidence that an employee of Ike Pono Medical Billing Hawaii or our associates has not adhered to the standards provided in our Policy and Procedure Guide, we will take actions consistent with the HIPAA rules and our own disciplinary policies, and document these actions accordingly. The HIPAA Privacy Rules give all individuals the right to file complaints to our client, our company, and the Office of the Secretary in the Federal Department of Health and Human Services. Under no circumstances will the fact that an individual has filed a complaint affect the services provided to that individual. Any employees found to be treating any individual differently in light of a complaint will be disciplined.

Procedure

Patients wishing to file a privacy complaint should be advised of the following:

- Individuals may submit privacy complaints regarding our company in the form of a letter containing all necessary information.
- All privacy complaints should be directed to the Compliance Manager.
- The complaint should describe the privacy concern in as much detail as possible.
- The complaint must include the following:
 - The type of infraction involved (Inappropriate handling of PHI, Appropriateness of privacy policies, etc.)
 - A detailed description of the incident or problem.
 - The date the incident or problem occurred, if applicable.
 - The mailing address to which a formal response may be sent.

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Procedure (Continued)

When a privacy complaint is received from a patient the following steps must be taken:

- The Compliance Manager must confirm that the patient has a complete and accurate understanding of the applicable rules and policies, being as courteous as possible. The patient should under no circumstances feel pressured or coerced regardless of their level of understanding.
- If the individual does not want to pursue the complaint any further, the statement “no further action required based on clearer understanding” will be indicated on the original complaint form along with the date and time, and it will be filed under dismissed complaints.
- We will investigate all non-dismissed complaints by discussing the circumstances with those involved and reviewing any relevant documentation. A summary of the findings will be recorded on the complaint form.
- If the complaint is determined to be invalid, a letter stating the reasoning for the determination will be drafted and mailed to the patient. A copy of the letter will be filed with the complaint form in the complaints file.
- If the complaint is determined to be valid, the responsible employees will be disciplined in accordance with policies adopted by the human resources department.
- Once disciplinary action has been taken with respect to the complaint, or if the response will take more than 30 days, a letter explaining the situation will be sent to the patient. A copy of the letter will be filed with the complaint form in the complaints file.

Assessing Risk Areas for Fraud, Waste and Abuse

General Policy

Risk areas in the claims management process will be assessed routinely by performing periodic reviews of billing practices to minimize the potential for inaccuracies that lead to fraud, waste and abuse. Ike Pono Medical Billing Hawaii does not participate in activities that violate the Federal False Claim Act, which defines fraudulent billing as knowingly making, using, or causing a false record or statement to be used in order to get a false or fraudulent claim paid or approved. False claims are subject to monetary penalty up to \$10,000 for each item or service improperly claimed in addition to an assessment of up to three times the amount claimed.

Procedure

Compliance with the laws governing fraud, waste and abuse will be maintained in the following ways:

- No false or fraudulent claims will knowingly be constructed or submitted to any payer for reimbursement. Any employee who knowingly participates in the submission of false or fraudulent claims will be terminated and reported to OIG for further legal action. All expenses incurred as a result of the incident will be recovered from the employee.
- In an effort to promote accuracy, prevent fraud and identify errors in our claims processing protocol, IPMBH will regularly conduct random audits of claims submitted by our office and routinely review MBA's billing practices and procedures.

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Role as a Clearinghouse

General Policy

Ike Pono Medical Billing Hawaii is considered a clearinghouse under the definition set forth by the Health Insurance Portability and Accountability Act (HIPAA). A clearinghouse is defined as a public or private entity that performs either of the following functions:

1. Processes or facilitates the processing of health information received from another entity, in a nonstandard format or containing nonstandard data content, into standard data elements or a standard transaction.
2. Receives standard transactions from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

Procedure

As a clearinghouse by definition under HIPAA, Ike Pono Medical Billing Hawaii acknowledges the following:

- Ike Pono Medical Billing Hawaii is subject to the Final Standards for Privacy and Individually Identifiable Health Information under HIPAA. Our policies reflect our adherence to HIPAA standards and will be strictly adhered to by all employees.
- Ike Pono Medical Billing Hawaii will abide by its Business Associate Agreement with each of its clients in respect to uses and disclosures of PHI.
- Ike Pono Medical Billing Hawaii will submit healthcare claims in a standard HIPAA format, often by way of additional clearinghouses such as Relay Health, McKesson, Change Healthcare, Office Ally and Emdeon.

Role as a Business Associate

General Policy

Ike Pono Medical Billing Hawaii will be considered a business associate to our clients under the definition set forth by HIPAA. A business associate is defined as an organization that, on behalf of a healthcare provider, performs or assists in the performance of any function or activity involving the use or disclosure of individually identifiable health information. This includes claims processing or administration, data analysis, utilization review, quality assurance, billing, benefit management, practice management, and re-pricing.

Procedure

As a business associate of our clients Ike Pono Medical Billing Hawaii will perform the following:

- Ike Pono Medical Billing Hawaii will submit transactions in a HIPAA standard format on behalf of our clients.
- Ike Pono Medical Billing Hawaii will perform all obligations outlined in our Business Associate Agreement as agreed upon with our clients.
- Ike Pono Medical Billing Hawaii acknowledges that it signs into a Business Associate Agreement with each client that meets required elements mandated by HIPAA, and that it meets and remains in compliance with all arrangements outlined in the agreement.
- Ike Pono Medical Billing Hawaii will make all internal documentation concerning its role as a business associate accessible when requested.
- Ike Pono Medical Billing Hawaii will determine if our clients have violated any HIPAA, Stark II or other pertinent regulations and address any violations with the client. IPMBH will assess the need for corrective action and/or immediate termination of our Business Associate Agreement and Billing Agreement. In addition, any suspected violation by IPMBH will be investigated internally and addressed with the client in a timely and honest manner.
- Ike Pono Medical Billing Hawaii will oversee the secure storage, return or destruction of all PHI received from or created on behalf of our clients.

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Second Tier Business Associates

General Policy

Independent contractors or agents contracted by Ike Pono Medical Billing Hawaii will be considered Second Tier Business Associates, by HIPAA definition. IPMBH is required to ensure that any agents, including subcontractors, to whom it provides protected health information, agree to the same restrictions and conditions that apply to the business associate with respect to such information.

Procedure

- Each independent contractor or business associate not employed by MBA Medical Billing will be required to sign a Second Tier Business Associate Agreement with Ike Pono Medical Billing Hawaii. prior to any exposure to protected health information.

- Second Tier Business Associates must acknowledge a full understanding of MBA's role as a HIPAA governed business associate of our clients.

Developing Proposals and Service Agreements

General Policy

The Client Implementation Manager will be responsible for addressing the range and degree of services to be provided to each specific client. These services will be outlined in the Billing Agreement approved by both the client and Ike Pono Medical Billing Hawaii.

Procedure

- The Client Implementation Manager will discuss with each potential client all available services relevant to the needs of their practice.
- The Client Implementation Manager will create a detailed business proposal outlining the full scope of services to be provided for each potential client.
- If the proposal is accepted, the Client Implementation Manager will produce a comprehensive Business Associate Agreement, a Billing Agreement, and a checklist indicating all information necessary for billing. Clients will read the agreements and sign them to acknowledge that they understand and agree to the terms.
- Services will commence when all documentation has been completed and returned and all conditions outlined in the billing agreement have been met.

Services, Responsibilities and Fees

General Policy

The Client Implementation Manager will be responsible for explaining to our clients all relevant services that our organization will provide. These services will be outlined in the Billing Agreement entered into by the client and by Ike Pono Medical Billing Hawaii. Additional services may be added and services may be discontinued or revised in description only with the acquiescence of both parties. The responsibilities of each party will be outlined and agreed upon within the original Billing Agreement and any additional amendments. Fees will be outlined in the Billing Agreement, which must be reinitiated upon any fee changes.

Procedure

The services provided to our clients are customized to fit the needs of each organization. In addition, the services can be amended with the approval of both IPMBH and our client. Taking into consideration the potential variation and changes in provided services both between and within individual client groups, the following is an itemized list of the services routinely provided to all clients by Ike Pono Medical Billing Hawaii:

- Charge Entry
- Claim Submission (Electronic Whenever Possible)
- Management of Accounts Receivable
- Payment Entry and Bank Deposit
- Patient Statement Submission
- Internal Collections and Patient Balance Review
- Management and Support of Information Systems and IPMBHNetwork
- Standardized Production Reports & Customized Reports
- Customized Encounter Forms
- Annual Fee Schedule Review
- Courier Service

The following services can be purchased in addition to routine services:

- Virtual Private Network Connection
- Online Access to Billing System
- Eligibility and Referral Management
- Consulting and Chart Auditing
- Payer Contract Negotiations
- Office Management
- Management of Accounts Payable

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The responsibilities of each party are clearly explained to the client prior to their start date with MBA. The typical breakdown of responsibilities is as follows:

Charge Entry

The client is responsible for providing a completed encounter form for each patient visit including the date of service, procedure codes, diagnosis codes, and demographic and insurance information for the patient, responsible party and subscriber.

Clients must code all procedures and diagnoses to assure that codes accurately reflect the documented services and conditions.

IPMBH is responsible for accurately posting the information into the appropriate billing system, submitting the claim to the patient's insurance, and maintaining organized files of charge batches.

Claim Submission

The client is responsible to complete and return all documentation necessary to engage in electronic data interchange with all insurance companies that are capable of receiving electronic claims.

IPMBH is responsible to submit claims electronically to all carriers and clearinghouses for which agreements are complete or not required.

IPMBH is responsible to submit paper claims only when electronic claim submission is not possible or unavailable.

Management of Accounts Receivable

The client is responsible to provide any patient information available as needed for claims processing in a reasonably timely manner.

IPMBH is responsible for assuring that all claims are paid by the correct payer, at the correct rate, in the timeliest manner possible.

Payment Entry and Bank Deposit

The client is responsible to provide IPMBH with deposit slips and an endorsement stamp for the bank where claim payments will be deposited.

IPMBH is responsible for posting payments to the appropriate claims and patient accounts and for maintaining organized files of payment batches.

IPMBH is responsible for depositing payments into the client's on a schedule agreed upon with the client.

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- Patient Statement Submission
- IPMBH is responsible to track balances and submit monthly statements to the patients when a balance remains after their insurance has processed their claim.
- Internal Collections and Patient Balance Review
- IPMBH is responsible for identifying patients who fail to make regular and adequate payments in an attempt to resolve their debt to our clients.
- IPMBH is responsible for evaluating the history of such patients and determining the appropriate course of action.
- IPMBH is responsible to execute any necessary steps to clear the debt including phone calls, collection letters, and turning accounts over to outside collection agencies.
- The client is responsible for determining, in a timely manner, if an account should be sent to an outside collection agency or written off as bad debt.
- IPMBH is responsible for providing all necessary information to external collection agencies and adjusting balances in the billing system to reflect our client's decision.
- Management and Support of Information Systems and IPMBH Network
- IPMBH is responsible to maintain and support our network and practice management systems and to assure that problems are resolved quickly, decisively, and correctly.
- IPMBH is responsible to maintain our end of any VPN connections to our office and to resolve any problems related to our information systems in a professional and timely manner.
- The client is responsible for maintaining and supporting any information systems or network connections outside of the MBA infrastructure. This includes the client's network, independent scheduling system, charting system, phone/voicemail system, internet connection, their side of any VPN connections, and any other hardware or software problems not under MBA's control.

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- Standard Production Reports and Customized Reports
- Clients are responsible to communicate any particular interest or concern that they would like to analyze in report form.
- IPMBH is responsible to provide monthly production reports indicating the count, total charges, total payments and total adjustments for each procedure billed during that month.
- IPMBH is responsible to provide a summary of the Accounts Receivable to the client at the end of every month.
- IPMBH is responsible to provide any reasonably producible customized reports to address client concerns as they come up. IPMBH will determine if a requested report is reasonably producible.
- Customize Encounter Forms
- The client is responsible to provide a list of the most commonly used procedure and diagnosis codes for initial encounter form design.
- IPMBH is responsible to periodically review the codes on our client's encounter forms to verify that the codes are active, the description is appropriate, and the most commonly used codes are listed.
- IPMBH is responsible to recommend encounter form changes to our clients.
- The client is responsible for indicating any changes they would like to see on their encounter form.
- IPMBH is responsible for designing encounter form templates to best accommodate the desired appearance and codes requested by our clients.
- The client is responsible for mass production of encounter forms.
- Annual Fee Schedule Review
- IPMBH is responsible for reviewing the existing fee schedules of our clients annually and suggesting optional changes that reflect regular revisions to procedure code values and prevailing rates.
- The client is responsible for making the final determination regarding their fee schedule.
- IPMBH is responsible to assure that the fees billed for each service match the fee schedule determined by the client.

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□ Fees

□ Fees are determined by IPMBH on a client-by-client basis, dependent on the range and degree of service provided to the client and the expense involved in their billing.

□ Fees are typically quoted as a percentage of receipts.

□ Services not included in the traditional package are billed in addition to the monthly rate; fees for such services are agreed upon before the services are provided.

Interruption of Client Service

General Policy

When a decision is required regarding client relations following suspected misconduct, the Client Implementation Manager will be responsible for determining the appropriate course of action. The Client Implementation Manager will be presented with information, either from IPMBH staff or from our client, to determine if circumstances warrant suspension, continuance or cancellation of services.

Procedure

Ike Pono Medical Billing Hawaii may suspend, continue or terminate services performed on behalf of our clients should circumstances warrant such action.

GROUNDINGS FOR ACTION

Circumstances warranting suspension include:

- Suspected or known misconduct as defined by the OIG (HIPAA Violations)
- Unpaid invoices, past due by 60 days or more
- Failure to uphold Ike Pono's expected standard of integrity

Conditions for reinstating or continuance of agreement:

- Evidence of appropriate and legal conduct in suspected problem areas
- Payment of outstanding invoices
- Amendment of practices representing an effort to reach expected standard of integrity

Cause for termination of Billing Agreement:

- Client is submitting false or fraudulent encounter forms
- Client is unethically and illegally assigning procedure or diagnosis codes
- Client has been brought under investigation by the OIG for misconduct
- Client has been placed on the OIG Excluded List
- Ongoing failure to uphold Ike Pono's expected standard of integrity

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ACTIONS TO BE TAKEN

When suspension has been approved by the Client Implementation Manger:

The client will be notified both orally and in writing within two (2) business days.

Documentation will be placed in the client's file.

IPMBH personnel will be notified in a special private briefing.

User access will be denied to the client's accounts and billing records.

When continuance has been approved by the Client Implementation Manager:

The client will be notified both orally and in writing within two (2) business days.

Documentation will be placed in the client's file.

IPMBH personnel will be notified in a special private briefing.

User access will be restored to the client's accounts and billing records.

When termination has been approved by the Client Implementation Manager:

The client will be notified both orally and in writing within two (2) business days.

Documentation will be placed in the client's file.

IPMBH personnel will be notified in a special private briefing.

User access will be denied to the client's accounts and other records.

After investigation of known or suspected misconduct is performed by IPMBH the management team will meet to determine if further action is required. If circumstances warrant additional action, the OIG Hotline will be contacted by the Compliance Manager to report the unresolved misconduct.

Physical Security

General Policy

All IPMBH staff should understand and support the control of access to protected health information. Upon detection of any breach of physical access, staff members are empowered to implement provisions of Ike Pono's Physical Security Procedures according to their best judgment, but all instances should be reported to the Compliance Manager for action and documentation.

The Systems Administrator has overall responsibility for physical security and for oversight of the procedures listed below. In the event that the Systems Administrator is unavailable, another manager will assume responsibility for the procedures in this policy.

Procedure

ZONE RESTRICTIONS

Definition of Areas:

- Zone 1: Areas open to the public
- Zone 2: Areas not open to the public, but open to clients and staff
- Zone 3: Areas not open to the public or clients, but open to staff
- Zone 4: Protected areas. Access is strictly controlled and only designated personnel are allowed.

All staff should be clearly aware of the zone types within each area of Ike Pono's facilities and should not hesitate to challenge any inappropriate access to an area.

EMERGENCY PROTOCOL

Emergency telephone numbers should be available to all employees. If possible, incidents and disasters should be managed by the Systems Administrator, but in emergency situations the call can be made by any staff member. In all instances, follow-up reports should be made to the Systems Administrator.

PHYSICAL INTRUSION OR DISASTER

When personnel are present:

- Staff should take the immediate, appropriate action to safeguard patient information and the physical and electronic infrastructure.
- The Systems Administrator, or the most available staff member should call the appropriate authorities to respond to the situation.
- In all instances, follow-up reports should be made to the Systems Administrator.

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Detected outside of hours of operation:

☐ If immediate action is necessary, arrangements should be made to contact the Systems Administrator, or another manager, who will contact the appropriate authorities and take any necessary steps to secure the premises until a complete evaluation of the damage can be made.

☐ In all instances, follow-up reports should be made to the Systems Administrator.

ROUTINE DESTRUCTION OF PROTECTED HEALTH INFORMATION

☐ All documents containing protected health information should be separated from regular trash and destroyed either by shredding or burning.

☐ When damaged, defective, or obsolete, all disks, tapes or any other storage medium containing PHI should be either erased or destroyed.

REPAIR AND ACCESS TO COMPUTER EQUIPMENT

☐ Access to equipment containing PHI by any service technician should kept to them minimum duration necessary to accomplish the desired job.

☐ Access to equipment by non-IPMBH personnel should be supervised or restricted to prevent inappropriate access to PHI.

☐ All non-IPMBH personnel should understand and sign a Second Tier Business Associate Agreement.

SECURING THE PREMISES

☐ All employees are responsible for closing and locking their window at the end of the day.

☐ After regular business hours, every employee should confirm that the front door to the office is locked as they leave the building.

☐ The side door is to remain locked at all times. The Systems Administrator will confirm daily.

☐ Upon termination of any employee for any cause, the pass code to the front door will be changed.

☐ The pass code to the front door will only be given to those employees whose schedule necessitates access before or after regular business hours.

☐ The pass code to the front door is only to be given out by a member of the management team. Any further dissemination is considered misconduct.

WORKSTATION USE

☐ Computers should be configured so that a screen saver appears when monitors are idle for 15 minutes. A password will be needed to return.

RECORD HANDLING

☐ Confidential records should not be left in a conspicuous location.

☐ All employees should pro-actively gather unattended records and return them to a secured area.

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System Maintenance & Control Logs

Responsibility

The Systems Administrator will be trained and responsible for assuring that system maintenance and changes described in this policy are properly conducted and documented. No other employees are permitted to perform these functions without the documented approval of the management team and proper technical and security training.

Installing Changes

Ike Pono Medical Billing Hawaii intends to keep current with vender changes, releases and versions

whenever appropriate. Minor changes and software updates shall be implemented at the discretion and timing of the Systems Administrator. Major changes, such as new systems or major purchases (Greater than \$1,500) require review and approval by all managers. While IPMBH strives to be on the leading edge of technology, it is our policy to avoid being a beta test site or making any other changes that could subject our clients to the negative effects of unproven products.

System Maintenance & Event Log

A manual log will be kept to record all maintenance and any other unusual activity. This log shall be updated without delay following any relevant activity. The log will be reviewed by the Systems Administrator, at an interval of no more than 6 months, to assure that proper maintenance and updates are performed and documented.

Inventory

A comprehensive inventory of all hardware, software, and network assets shall be maintained by the Systems Administrator. Any changes to software versions or physical inventory will be reflected in the log.

Contingency Plan

Purpose

The purpose of this contingency plan is to define the steps to be taken to protect our information systems against data loss in event of a system failure or accident. Our plan explains the procedure for the backing-up of data, restoration of data, and the continuation of operations during an interruption of services such as system downtime, a brief power outage, or other disruption of our information systems. The focus is on measures taken to protect our data and information systems in order to insure complete restoration to the state existing prior to any interruption of service.

Definitions

Backup refers to the duplication of information necessary to restore a system should the system become inoperable for any amount of time.

Disaster Recovery Planning is the preparation for the event of a disaster in which information systems are destroyed or significantly inoperable for an extended period of time.

Criticality Analysis refers to the prioritization of information systems for the extensiveness of their backup, contingency, disaster recovery planning and restoration testing. More critical systems are those directly related to patient service or high priority business system functions.

Criticality Analysis

INFORMATION SYSTEMS

The following systems and associated data are considered critical to the ongoing provision of patient service and all reasonable efforts will be made to have them operational and accessible at all times:

- Misys Tiger Practice Management System
- Nightly data backup – 4mm Cartridge
- PPM Anesthesia Management System
- Nightly data backup – Windows 2000 Server
- Windows 2003 Terminal Server
- Windows 2000/PPM Server
- MBA1 Data Server
- Novell Client System

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HIGH PRIORITY BUSINESS SYSTEMS

The following systems and associated data are considered critical to business operations and all reasonable efforts will be made to allow complete system recovery from any system failures:

- Phone System
- Web Server
- Voicemail System
- QuickBooks Accounting Software

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MANUAL DOWNTIME PROCEDURES

Should any of the critical information systems experience downtime we will revert to manual procedures for capturing data, accessing data from manual files, and updating patient records. We will use manual processes until the relevant systems are operational, at which time the systems will be updated to reflect any manual processes that occurred.

Manual forms to be kept and used in the event of downtime include:

- Claim Forms
- Deposit Logs
- EOB Files
- Encounter Form Files
- Conversation Notes

For certain systems, operational failure requires the discontinuance of any activities that are dependent on the system. The day to day services at IPMBH will continue in the absence of these activities for system failures lasting less than 48 hours. Should the system failure extend beyond 48 hours, alternative means will be implemented by the management. Systems falling under this category include:

- Phone System
- Voicemail System
- Web Server
- QuickBooks Accounting Software

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Disaster Recovery Plan

Purpose

This plan is intended to define the step to be taken in the event of a disaster or catastrophic incident that renders our information systems unusable for an extended period of time, which IPMBH defines as a period expected to exceed 5 business days. Examples of such events include fire, tornado, hurricane, and explosion. The focus is on developing plans to enable quick and effective replacement of key systems and an acceptable environment to enable us to operate key systems following a disaster.

Restoration Hierarchy

In the event of a disaster, attention will be focused on restoring operational status to critical systems first. Attention should be prioritized to facilitate the restoration of systems in the following order:

1. Misys Tiger AIX Server
2. WTS 2000/PPM Server
3. Windows 2003 Server
4. MBA1 Data Server
5. Novell Client Software
6. Phone System
7. Novell GroupWise Email System
8. Voicemail
9. Linux Web Server
10. QuickBooks Accounting Software

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Strategic Operations Plan

In the event that a disaster incapacitates our primary office facility, the following plan will be implemented under the supervision of the Systems Administrator:

□ Integrated Information Systems has agreed to provide emergency set up of computer and network services on short notice. IIS will dedicate all of their resources to restoring operational status to MBA's systems in the primary facility, if possible, or in a temporary facility.

□ Temporary Work Site

□ If the Systems Administrator determines that Ike Pono's center of operations will be incapacitated for an extended period of time (greater than 5 business days) a temporary work site will be set up within 24 hours of such determination.

□ Operations will resume at the temporary work site and any necessary systems will be set up at the site as soon as they are functional.

□ The budget for the emergency set up of a temporary work site will not exceed \$20,000. The following interim locations will be considered in this order:

1. The residence adjacent to the IPMBH Building
2. An office space or conference room in the Vancouver area
3. An office space or conference room in the Portland area

□ The management team will determine if it is practical to restore permanent operation at the IPMBH facility or move operations to a new permanent facility.

Restoring Information Systems

We will maintain a constant state of readiness for a disaster by maintaining the following resources:

□ Current technical configurations and requirements are available locally from Misys Healthcare Systems in Vancouver, Washington.

□ Current copies of software applications, operating systems, middleware, databases and other software related resources are maintained onsite for each of our critical systems.

□ Data and files are backed up regularly as described in our Contingency Plan. Backup cassettes are stored offsite.

Testing the Recovery Plan

We will test our disaster recovery plan annually. The intent is to assure that the resources will be reasonably available, that procedures for restoring systems and data work

properly, and employees responsible for executing the recovery are comfortable with their training and level of readiness.

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Declaring a Disaster

Due to the considerable cost, effort and disruption caused by implementing the disaster plan, IPMBH will be prudent in declaring an operational emergency. As soon as possible after a disaster or catastrophic event, an assessment of our operational abilities will be made by the CEO and/or the Systems Administrator. If they determine that the situation warrants it, both the CEO and the Systems Administrator have the authority to declare a disaster.

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