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Owner	Jane Gray
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References	Policy

Billing and Collections

SCOPE:

This Policy applies to all Phoebe Putney Health System (PPHS) hospital facilities.

PURPOSE:

PPHS, as a not-for-profit charitable corporation, is committed to ensuring its hospitals fulfill their charitable missions by providing high quality medical care to all patients in their service areas, regardless of their financial situation. It is the goal of this policy to provide clear and consistent guidelines for conducting billing and collection functions in a manner that promotes compliance, patient satisfaction, and efficiency.

Through the use of billing statements, written correspondence, and phone calls, PPHS hospitals will make diligent efforts to inform patients of their financial responsibilities and available financial assistance options, as well as follow up with patients regarding outstanding accounts.

Additionally, this policy requires PPHS hospitals to make reasonable efforts to determine a patient's eligibility for financial assistance under PPHS's Financial Assistance Policy before engaging in collection actions to obtain payment.

POLICY:

After our patients have received services, it is the policy of PPHS hospitals to bill patients and applicable payers accurately and in a timely manner. During this billing and collections process, staff will provide quality customer service and timely follow-up, and all unpaid accounts will be handled in accordance with the IRS and Treasury's 501(r) final rule under the authority of the Affordable Care Act. Hospital billing and collections are administered by the Revenue Cycle of each PPHS hospital, with authority and approval from each hospital's Board of Directors.

DEFINITIONS

Financial Assistance Program (FAP): PPHS program that provides financial assistance to persons who have emergent and/or medically necessary healthcare needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for such care based on their individual financial situation, and who meet the requirements contained within the PPHS Financial Assistance Policy.

Reasonable Efforts: A certain set of actions each PPHS hospital must take in compliance with 26 CFR § 1.501(r) to determine whether an individual is eligible for financial assistance under the PPHS Financial Assistance Policy. In general, reasonable efforts include the following as well as other additional actions deemed to further reasonable efforts: providing individuals with written and verbal notifications about the FAP, FAP application processes, certain collection actions that the PPHS hospital intends to take, the deadline after which certain collection actions may be taken, and a plain language summary of the FAP not less than thirty (30) days before engaging in certain collection actions, posting of information about the FAP on the PPHS website, and other public dissemination of such information.

PPHS Hospital Facilities: Phoebe Putney Memorial Hospital (PPMH), Phoebe Sumter Medical Center (PSMC), and Phoebe Worth Medical Center (PWMC).

PROCEDURE

I. **Financial Expectations**

Consistent with this Policy and the Financial Assistance Policy, PPHS hospitals will clearly communicate with patients regarding financial expectations as early in the appointment and billing process as possible.

- Patients are responsible for understanding their insurance coverage and for providing needed documentation to aid in the insurance collection process.
- Patients may be required to pay a pre-service deposit or estimated co-pays and deductibles prior to services (except in the Emergency Department and other emergent situations) or amounts may be collected after services are provided, based on the current business practices of individual PPHS sites.
- Patients are generally responsible for paying self-pay balances, including any amounts not paid by insurance companies or applicable third party payers.
- If the patient has a previous bad debt or outstanding balance, PPHS hospitals may request amounts owed or a payment plan commitment with an initial payment before future appointments for non-emergency services are granted. If arrangements cannot be made for resolving the patient's outstanding balance, future non-emergency care may be limited or denied, if clinically appropriate after discussion with the treating physician. Pre-service deposits may be required for non-emergency services.

II. **Pre-service Financial Clearance**

A. Elective Patients

1. Insurance is verified by Pre-Registration/Insurance Verification team.
2. Any patient liability (deductible, co-insurance, co-pay) is determined and recorded in Account Notes and in the online eligibility system.
3. Pre-Registration will notify the patient of the estimated out of pocket cost, as recorded in account notes, and request payment due. Collection attempts will be made and information provided on uninsured discounts, prompt pay discounts, payment plans and financial assistance.
4. If an uninsured patient is admitted into a PPHS hospital, a representative acting on behalf of PPHS may visit the patient. This representative will educate the patient concerning discounts, payment plans and financial assistance. This representative may make referrals to the following agencies for potential Medicaid eligibility:
    - Department of Family and Children's Services
      OR
    - A contracted third party eligibility vendor
5. Non-scheduled and scheduled patients that are not processed through Pre-Service will undergo insurance verification at the point of service. Patients who present to the Patient Access Specialist (PAS) at point of service, with patient liability information recorded in account notes will be asked to sign any waivers (ABN, Self pay, etc.) and pay the amount due (i.e.: deductible, co-insurance, co-pay, and/or non-covered services). At all points of registration, collection attempts will be made and information provided on uninsured discounts, prompt pay discounts, payment plans and financial assistance.

B. Urgent or Emergency Care

Any patient seeking urgent or emergent care [within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)] at a PPHS Hospital Facility shall be treated without discrimination and without regard to a patient's ability to pay for care. PPHS Hospital Facilities shall operate in accordance with all federal and state requirements for the provision of urgent or emergent health care services, including screening, treatment and transfer requirements under the federal Emergency Medical Treatment and Active Labor Act (EMTALA). This policy prohibits any action that would discourage individuals from seeking emergency medical care (EMC) including but not limited to demanding pay before treatment for emergency medical conditions or by permitting debt collection activities that interfere with the provision, without discrimination, of EMC.

III. **Billing Practices**

A. Insurance Billing

Please note that it is the patient's responsibility to know their insurance benefits and coverage prior to their services at PPHS. All required referral(s) or authorizations must be secured prior to services, except in an emergency. Patients who have

questions regarding financial responsibility or coverage of services at PPHS, are encouraged to contact their insurance carrier in advance of services.

1. For all insured patients, PPHS hospitals will bill applicable third-party payers (as based on information provided by or verified by the patient) in a timely manner.
2. If a claim is denied (or is not processed) by a payer due to an error on our behalf, PPHS hospitals will not bill the patient for any amount in excess of what the patient would have owed had the payer paid the claim.
3. If a claim is denied (or is not processed) by a payer due to factors outside of our organization's control, staff will follow up with the payer and patient as appropriate to facilitate resolution of the claim. If resolution does not occur after prudent follow-up efforts, PPHS hospitals may bill the patient or take other actions consistent with current regulations and industry standards.

B. Patient Billing

1. Inpatient accounts will receive a summary statement after discharge. The Summary Bill includes the summary of charges and includes financial assistance information. If the patient has insurance, the statement is informational and no amount will be due from the patient until the insurance claim has been settled.
2. All uninsured patients will be billed directly and timely, and will receive a statement as part of the organization's normal billing process. The statement will include information on the FAP.
3. For insured patients, after claims have been processed by third-party payers, PPHS will bill patients in a timely fashion for their respective liability amounts as determined by their insurance benefits. The statement will include information on the FAP.
4. All patients may request an itemized statement for their accounts at any time.
5. If a patient disputes his or her account and requests documentation regarding the bill, staff members will provide the requested documentation. Patient requested audits may result in a change to the billed amount to increase or decrease the total bill, based on supporting clinical documentation.
6. PPHS hospitals may approve payment plan arrangements for patients who indicate they may have difficulty paying their balance in a single installment. In some situations, PPHS hospitals may engage a third party to provide account management for their payment plans.

   PPHS hospitals are not required to accept patient-initiated payment arrangements and may refer accounts to a collection agency as outlined below if the patient is unwilling to make acceptable payment arrangements or has previously defaulted on an established payment plan.

IV. **Collections Practices**

A. In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Billing and Collections Policy, PPHS hospitals may engage in collection activities to collect outstanding patient balances.

1. General collection activities may include follow-up calls and statements.
2. Patient balances may be referred to a third party for collection at the discretion of PPHS hospitals, to include reporting unpaid debts to credit reporting agencies and /or credit bureaus. Phoebe will not refer an unpaid account to a third party collection agency for at least 120 days from the first post-discharge statement and will only do so after making reasonable efforts to determine whether an individual is eligible for assistance under the FAP.
3. PPHS hospitals will maintain ownership of any debt referred to debt collection agencies, and patient accounts will be referred for collection only with the following caveats:
    a. There is a reasonable basis to believe the patient owes the debt.
    b. All third-party payers have been properly billed, and the remaining debt is the financial responsibility of the patient.
    c. PPHS hospitals will not refer accounts for collection while a claim on the account is still pending payer payment. However, PPHS hospitals may classify certain claims as "denied" if such claims remain in a "pending" mode for an unreasonable length of time, despite efforts to facilitate resolution.
    d. PPHS hospitals will not refer accounts for collection when the claim was denied due to a PPHS hospital error. However, PPHS hospitals may refer the patient liability portion of such claims for collection if unpaid.
    e. PPHS hospitals will not refer accounts for collection where the patient has submitted a completed application for financial assistance or other PPHS-sponsored program and the PPHS hospital has not yet notified the patient of its determination (provided the patient has complied with the timeline and information requests delineated during the application process).
    f. PPHS hospitals may refer accounts if patients were uncooperative in making payments, have not made appropriate payments, or have been unwilling to provide reasonable financial and other data to support their request for charity care or financial assistance.
4. Collection agencies and law firms may be enlisted after all reasonable internal collection and payment options have been exhausted. Collection agency and law firm staff will uphold the confidentiality and individual dignity of each patient. All agencies and law firms will comply with all applicable laws including HIPAA requirements for handling protected

health information, 26 CFR § 1.501(r), and the Fair Debt Collection Practices Act.

5. PPHS hospitals may pursue legal action against patients who keep insurance payments or settlement proceeds related to medical services received that are properly due to the hospital and patients who refuse to pay a bill and are not eligible for financial assistance or have not cooperated in the process to make that determination. Authorization to take legal action against a patient for the collection of medical debt will be provided on a case-by-case basis.

V. Extraordinary Collection Actions (ECA)

Actions that PPHS hospital may take, or authorize a collection agency or law firm to take, related to obtaining payment of a bill for medical care include the following:

1. PPHS hospitals may defer or reschedule non-emergent services, if clinically appropriate after discussion with the treating physician, until payment is received or payment arrangements are made.
2. Reporting unpaid debts to credit reporting agencies and/or credit bureaus after a minimum of 120 days from the first post-discharge statement, and will only do so after making reasonable efforts to determine whether an individual is eligible for assistance under the FAP.
3. Actions that require legal or judicial process including, but not limited to:
    - Commencing a civil action or lawsuit against the patient or responsible individual;
    - Garnishing an individual's wages after securing a court judgment;
    - Attaching or seizing an individual's bank account, other personal property, or other judgment enforcement action permissible under state law after securing a judgment.
4. ECA's will be suspended upon submission of an incomplete or complete FAP application, and the account will be returned to the PPHS hospital.
5. Upon determination of FAP eligibility, all reasonable actions will be taken to reverse any ECA, and any amount paid for care in excess of patient responsibility amount determined by the FAP will be, first, applied to any other outstanding balances due, then, refunded to the patient.
6. PPHS Patient Financial Services Department will have the final authority for determining the PPHS hospital has made reasonable efforts to determine wither an individual is FAP eligible, and therefore may proceed with an ECA.

VI. Notification Period

ECAs for hospital services will not commence for a period of 120 days after the date of the first post-discharge billing statement for the applicable medical care received and only after making reasonable efforts to determine whether an individual is eligible for assistance under the FAP.

VII. **Financial Assistance**

PPHS Hospital Facilities will extend free or discounted care to eligible individuals for medically necessary services. The FAP applies to medically necessary services that are not elective in nature. Please refer to the PPHS policy detailing the Financial Assistance Program.

REFERENCES:

Patient Protection and Affordable Care Act, Public Law 111-148 (124 Stat. 119 (2010))
Internal Revenue Service Regulations s. 1.501(r)-1 through s. 1.501(r)-7

Approval Signatures

Step Description	Approver	Date
Final Approval	Brian Church: Sr. Vice President/CFO	06/2022
Legal Review	Janine Sarti: Deputy General Counsel	06/2022
	Jane Gray: VP, Revenue Cycle	06/2022