Billings and Collection Policy and Procedure

Distribution: All Employees	Approved by: Jessica Quattlebaum
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SCOPE: Policy applies to Wills Memorial Hospital (WMH) services.

POLICY STATEMENT: After our patients have received services, it is the policy of WMH to bill patients and applicable payers accurately and in a timely manner. WMH Staff will provide quality customer service and timely follow-up during this billing and collections process. In addition, all accounts will be handled in accordance with the IRS and Treasury's 501(r) final rule under the authority of the Affordable Care Act. WMH Billing and Collections are administered by the WMH Patient Financial Services Department.

DEFINITIONS:

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

Reasonable Efforts: A certain set of actions hospital must take in compliance with 26 Code of Federal Regulations 1.501(r) is to determine an individual's eligibility for financial assistance under the hospital's Financial Assistance Policy. In general, reasonable efforts include the following as well as other additional actions chosen to further reasonable efforts:

- Providing individuals with written and verbal notifications about the FAP,
- Develop a FAP application process,
- Identify specific collection actions that the hospital intends to take,
- Provide notification of the deadline after which certain collection actions may be taken,
- Supply a plain language summary of the FAP not less than thirty (30) days before engaging in certain collections,
- Provide information about the FAP on the WMH website and through other public methods.

PURPOSE:

The Hospital Authority of Wilkes County dba Wills Memorial Hospital (WMH) is committed to ensuring its hospital and clinics fulfill their charitable missions by providing high quality medical care to all patients in their service areas, regardless of their financial situation. The goal of this policy is to provide clear and concise guidelines for conducting billing and collection processes in a manner that promotes compliance, patient satisfaction and efficiency.

WMH will make diligent efforts to inform patients of their financial obligations and available financial assistance opportunities, as well as follow up with patients in regard to outstanding accounts. To inform

patients of the aforementioned, WMH utilizes billing statements, written correspondence, phone calls, and email.

This policy also requires WMH to make reasonable efforts to determine a patient's eligibility for financial assistance through the WMH Financial Assistance Plan before engaging in collection actions to obtain payment.

PROCEDURE:

A. Financial Expectations:

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

1. Patients are responsible for understanding their insurance coverage and for providing required documentation to aid in the insurance collection process.
2. Patients may be required to pay a pre-service deposit, or estimated co-pays and deductibles prior to services being rendered except in the Emergency Department and in other emergent situations).
3. Patients are generally responsible for paying self-pay balances, including any amount not paid by insurance companies or applicable third-party payers.
4. An immediate 25% Prompt Pay Discount may be applied prior to the service being rendered but may only be applied to uninsured patients or to expected deductible only balances of insured patients. **Insurance Copays and Coinsurance balances are NOT eligible for any further discounts.**
5. In the case that a patient has a previous bad debt or outstanding balance, WMH may request amounts owed, or a payment plan commitment with an initial payment prior to future appointments being granted for non-emergent services. If arrangements cannot be made for resolving the patient's outstanding balance, future non-emergent care may be limited or denied, if deemed clinically appropriate after discussion with treating physician. Pre-service deposits may be required for non-emergent services. Documentation of all referral services that are either refused or cancelled by the patient and/or WMH Patient Financial Rep will be maintained by the Patient Financial Representative for up to 7 years.
6. If 100% of the upfront collections estimate cannot be collected prior to rendering services a payment arrangement must be established by the Patient Financial Rep in the Business Office before scheduling services. The Patient Financial Rep is responsible for establishing all payment plan arrangements. Any arrangement made where less than 50% of the estimated upfront collections are obtained will require Patient Financial Services Director approval.
7. If an uninsured patient is admitted to WMH, a hospital Financial Representative will visit the patient. This representative will educate the patient concerning discounts, payment plans, and financial assistance. In addition, this representative may make referrals to the following agencies for potential Medicaid eligibility:
    a. Department of Family and Children's Services or
    b. A contracted third-party eligibility vendor.

B. <u>Pre-Service Financial Clearance:</u>

1. Elective Patients – Complete the WMH Insurance/Self Pay Worksheet including
    - Insurance is verified by Central Scheduling Staff.
    - Document any patient liability (deductible, co-insurance, copay, etc.) that is determined through the use of the online eligibility system.
    - Central Scheduling Staff will notify the patient of the estimated out-of-pocket cost, as recorded on the Worksheet prior to scheduling services.
    - Non-scheduled and scheduled patients not processed through Central Scheduling will undergo insurance verification at 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 required to sign any waivers (Advanced Beneficiary Notice (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.

C. <u>Billing Practices:</u>

1. Insurance Billing:
   Please note that it is the patient's responsibility to know their insurance benefits and coverage prior to applying for and receiving services at WMH. All required referral(s) or authorizations must be secured prior to services, except in an emergency situation. Patients who have questions regarding financial responsibility or coverage of services at WMH, are advised to contact their insurance carrier in advance of services.
    - For all insured patients, WMH will bill applicable third-party payers (as based on information provided by or verified by the patient) in a timely manner.
    - If a claim is denied (or is not processed) by a payer due to an error on our behalf, WMH will not bill the patient for any amount in excess of what the patient would have owed had the payer paid the claim.
    - If a claim is denied (or is not processed) by a payer due to factors outside of our organization's control, WMH staff will follow-up with the payer and patient as appropriate to facilitate resolution of the claim. If resolution does not occur after reasonable follow-up efforts, WMH may bill the patient or take other actions consistent with current regulations and industry standards.

2. Patient Billing:
    - 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.
    - For insured patients, after claims have been processed by third-party payers, WMH will bill patients in a timely manner for their respective liability amounts as determined by their insurance benefits. The statement will reference the WMH FAP.

- An itemized statement may be requested by patients.
- If a patient disputes their account and requests documentation regarding their 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.
- WMH may approve payment plan arrangements for patients who indicate they may have difficulty paying their balance in a single installment. In some situations, WMH may engage a third party to provide account management for their payment plans.
- WMH is 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.

D. <u>Collections Practices:</u>

1. Incompliance with relevant state and federal laws, and in accordance with the provisions outlined in this Billing and Collections Policy, WMH may engage in collection activities to collect outstanding patient balances.
    - General collection activities may include follow-up calls, statements, and email.
    - Patient balances may be referred to a third party for collection at the discretion of WMH, to include reporting unpaid debts to credit reporting agencies and/or credit bureaus. WMH 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 through the WMH FAP. The patient will be notified by U.S First Class Mail prior to the account being turned over to collections.
    - WMH 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 reason to believe the patient owes the debt.
        b. All third-party payers have been properly billed, leaving the remaining debt as the financial responsibility of the patient.
        c. While a claim on the account is still pending payer payment, WMH will not refer account for collection. However, WMH may classify claims as “denied” if such claims remain in a “pending” status for an unreasonable length of time, despite efforts to facilitate resolution.
        d. WMH will not refer accounts to collection when the claim was denied due to WMH error. However, WMH may refer any unpaid patient liability portion of such claims for collection.
        e. WMH will not refer accounts to collection when the patient has submitted a completed financial assistance application and in the case WMH has not yet notified the patient of its determination (provided the patient has complied with application timeline and process).

f. WMH may refer accounts to collections if patient was uncooperative in making payments, has not made appropriate payments, or has been unwilling to provide reasonable financial and other information to support their request for indigent care or financial assistance. Prior to turning any account over to collections, the patient will be notified by mail.

- 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 standards for handling protected health information, 26 CFR 1.50(r), and the Fair Debt Collection Practices Act.
- WMH may pursue legal action against patients who keep insurance payments or settlements proceeds related to medical services received, and that are due to the hospital. In addition, legal action may be pursued against patients who refuse to pay a bill and are not eligible for financial assistance or who have not cooperated in the financial assistance 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. Prior to pursuing any legal action, the patient will be notified of pending actions by Certified Mail.

E. <u>Extraordinary Collection Actions (ECA):</u>

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

1. If deemed clinically appropriate after discussion with treating physician, WMH may defer or reschedule non-emergent services until payment is received or payment arrangements are made. Documentation on all unfulfilled referrals will be maintained by the Patient Financial Services Rep for a period of 7 years.
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 WMH 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. Upon return of accounts from collection agencies, magistrate court, etc. following a reasonable attempt to collect monies for services, a determination will be made if the account qualifies for a specific Bad Debt category. At that time, the account will be appropriately classified in the appropriate financial class.

5. **PRM-1 312. INDIGENT OR MEDICALLY INDIGENT PATIENTS**

In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiary's indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. For patients with 661/662 Medicare plans, where the state of Georgia absorbs the cost of the Medicare Premium, Will Memorial Hospital considers these accounts indigent. As such, the reasonable collection efforts, also known as the 120-day rule, is not applicable.