Policy Statement

It shall be the policy of St. Joseph's/Candler Health System (SJ/C) to establish and maintain a policy for the handling of patient's with Out of Network (OON) insurance coverage. This policy will outline the definition of OON, the handling of OON patients, and cover several scenarios in which patients arrive to SJ/C with OON coverage.

Definition of Terms

Emergency Medical Services – means the medical services, as defined by EMTALA inclusive of all services related to providing a medical screening examination and stabilizing treatment in an emergency department or other department of a hospital in relation to the emergency visit.

Licensed Independent Practitioner (LIP) – physician or any other individual permitted by law and by the Hospital to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

Out of Network (OON) – when a provider or facility does not have a contract with the patient's insurance.

Applicability

This policy is applicable to all SJ/C facilities and providers for which SJ/C or an affiliate SJ/C entity bills. All LIP members of the medical staff who provide services at SJ/C or its affiliate entities, but who are not affiliated with SJ/C and for whom SJ/C does not bill are expected to independently ensure that they are in compliance with all relevant federal and state laws discussed in this policy.

Summary

If a doctor or facility does not have a contract with an insurance plan, they are considered to be Out-of-Network. Out-of-Network providers may be permitted to bill for the difference between what the OON insurance plan actually pays and the amount charged by the OON

provider for a service. This is called "balance billing." Balance billing is acceptable only in limited scenarios and must follow federal and state guidelines including the No Surprises Act and Georgia's Surprise Billing Law. Balance billing is not permitted for patients with an emergency medical condition. In addition, prior to any balance billing for non-emergencies, patients must be provided with certain mandatory notices.

Procedures

A. Emergency Services:
   1. Prohibition on Balance Billing: Patients with an emergency medical condition who receive emergency services from SJ/C (whether such patients present to the SJ/C seeking Emergency Medical Services or are transferred to the SJ/C Emergency Department from another provider) may not be balance billed. SJ/C may bill, at most, the equivalent patient's plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). This includes all Emergency Medical Services, as defined above, provided in an SJ/C Emergency Department and provided in an SJ/C facility (such as to inpatients or observation patients) where such care continues to meet the definition of Emergency Medical Services.
   2. Determination of Cost Sharing Amount: Determination of the patient's in-network cost-sharing amount will be determined by the amount on the patient's insurance card, if available. Thereafter, the bill will be sent to the patient's insurance carrier, which determines any remaining unmet in-network cost-sharing amount, such as an unmet deductible. If SJ/C receives notice that the patient has an unmet in-network cost-sharing amount, SJ/C may bill the patient up to such amount. SJ/C receives this amount after insurance processing, or will calculate the amount owed by the patient, up to their unmet cost-sharing amount, by classifying the patient as a self-pay patient and providing the patient with an 85% discount.

B. Post Stabilization Services:
   1. Prohibition on Balance Billing: Patients who presented to SJ/C with an emergency medical condition and who have been stabilized, but who may still remain patients of SJ/C for the condition related to their emergency visit (such as in an inpatient or observation unit or other department of the hospital) may not be balance billed and may only be billed the equivalent of the patient's plan's in-network cost-sharing amount unless the patient gives written consent to be billed for post-stabilization services.
   2. When Notice and Consent to Balance Bill is Appropriate: A provider or emergency facility can provide notice and request written consent from an individual to waive their balance billing protections only if all the following requirements are met:
      a. An individual is stable enough to travel using nonmedical or nonemergency medical transport to an available in-network provider/facility located within a reasonable travel distance given the individual's medical condition. This must be

determined by an attending emergency LIP or treating provider whose determination is binding on the facility.

b. The individual or their authorized representative is in a condition where they can receive information and provide informed consent. This must be determined by an attending emergency LIP or treating provider. An authorized representative CANNOT be a provider affiliated with the facility or an employee of the facility, unless such provider or employee is a family member of the participant, beneficiary, or enrollee.
c. The provider/facility provides written notice and obtains written consent from the individual to waive balance billing protections, in compliance with all related statutory and regulatory requirements.
d. The provider/facility complies with state laws.

3. Providing Notice and Obtaining Consent: When giving notice and seeking consent from individuals to waive their balance billing protections under the No Surprises Act, SJ/C must use standard notice and consent documents developed by the Department of Health and Human Services.

   The standard notice and consent documents were published as part of CMS Form Number 10780 and are available for download on CMS.gov:

   https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780

   SJ/C will tailor the standard notice with individual and provider-specific information.

4. Determination of Cost-Sharing Amount SJ/C May Charge: When patients *do* not consent to waive their balance billing protections or when it is otherwise inappropriate to request such consent, SJ/C may only bill the applicable cost-sharing amount that the patient would owe if they were in network. This cost sharing amount may be determined in the same manner described above in section A.2.
5. Procedure for determining status: When patients arrive at an SJ/C Emergency Department (ED) (whether on their own or via transfer from another facility), they are immediately triaged and provided a medical screening examination and necessary stabilization services in accordance with EMTALA guidelines. Once the patient is triaged, a "quick registration" is completed and SJ/C verifies whether the patient has been seen in our facilities previously. If they have, prior information will be pulled into the account. Once the patient is placed in a treatment room the registrar completes a full registration on the patient and verifies the patient's insurance (provided that such registration will not delay any medical screening or stabilizing treatment). If the patient's insurance is OON, an alert and indicator is placed on the account. The special indicator will also be placed on the ED tracking board. For patients who, as governed by EMTALA, are determined not to have an "emergency medical condition" or who have been stabilized, as defined by EMTALA, but who nevertheless meet the medical

necessity requirements for admission to inpatient or observation, then the procedure for providing notice and seeking consent to balance bill the patient, as described in section B.2. may be initiated.

C. Air Ambulance:

If SJ/C, now or in the future, operates an air ambulance service, it may balance bill any out of network patient for provision of such services. SJ/C may bill, at most, the equivalent patient's plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). This cost sharing amount will be determined as described in section A.2.

D. Certain Services at In-Network Hospital or Ambulatory Surgical Center:

Generally, out-of-network providers are banned from balance billing an individual who gets covered, non-emergency services that are part of a visit to an in-network health care facility. Overall, provided that SJ/C is in-network, this provision is inapplicable to SJ/C. However, all non-employed SJ/C medical staff or any other provider that provides medical services at SJ/C should be aware of their legal responsibilities to the extent any such provider is not in network with all of SJ/C's insurer contracts.

When entering into contracts with non-employed providers, such as professional services agreements, it will be SJ/C's policy to endeavor to include contractual provisions that require such providers to be in network with SJ/C's major insurers, to the extent possible. It shall further be SJ/C's policy to encourage its non-employed medical staff members to be in-network with its major insurers, and in all other respects to ensure that they are in compliance with all relevant laws regarding notice requirements if they are not in network with a particular insurer.

E. Requests for Admission from Other Sources:
When an outside health facility requests to transfer a inpatient at its facility for direct admission to SJ/C as an inpatient, a request for the patient's demographics and insurance will be sent. The transfer center will compare the insurance to a list of OON insurances. If an insurance is identified as OON, it will be referred to Utilization Management (UM) with a copy of the face-sheet. UM will verify the insurance is OON. Once verified, UM will notify the Transfer Center and the Transfer Center will notify the source of the transfer that the patient should be transferred to an in-network facility.

F. Pre-Scheduled Services:
Pre-Scheduled services will be screened by the Pre-Services team prior to treatment. If the Pre-Services department identifies the patient's insurance is OON, they will notify the patient and refer the patient to their health insurer, to identify another facility that is in-network with the patient's insurance. Patients with insurance that is OON will not be financially cleared for scheduled procedures. Only in certain circumstances, patients with

OON insurance can be financially cleared, with the approval of the Vice President of Revenue Cycle or higher. If approval is obtained and the patient decides to continue treatment at SJ/C as an elective self-pay, the Pre-Services team will follow the **Patient Financial Clearance (Administrative Policy #1227-A)** and complete a financial agreement with the patient, which includes an estimate of services.

G. Interfacility Transfers:

Patients will occasionally need to be transferred between hospitals within SJ/C. In this case, the patient will already be registered and the special OON indicator will be on the account. The provider will check for that indicator. If the indicator is present, the provider will enter an order for the transfer to an in-network facility to the extent such facility is available. If the indicator is absent, the order to transfer within the health system will occur. The receiving unit secretary or nurse will check for the indicator once more. If the indicator is present, the patient's provider will be notified in order to enter an order for transfer to an in-network facility to the extent possible. If the receiving unit secretary or nurse does not see the OON indicator, they will call patient placement to request a bed/transfer. At this time, the Transfer Center will verify the patient's insurance once more.

H. Public Disclosure Requirements:

SJ/C will make available to all patients, and potential patients, information about balance billing protections. The disclosure notice must be publicly available, and posted on SJ/C's public website.

1. To satisfy the public disclosure requirement, SJ/C will prominently display a sign with the required disclosure information in a location that is visible and accessible such as, where individuals schedule care, check-in for appointments, or pay bills, unless the provider doesn't have a publicly accessible location.
2. To satisfy the separate requirement to post the disclosure on a public website, the disclosure or a link to the disclosure must appear on a searchable homepage of the provider's or facility's public website.
3. In general, SJ/C must make available the disclosure notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, including covered individuals in a health benefits plan under the Federal Employees Health Benefits Program, and to whom they furnish items or services, and then only if such items or services are furnished at a health care facility, or in connection with a visit at a health care facility.

NOTE: Policies are intended to serve as training tools and as general guidelines for when questions arise or when unusual events occur. Personnel should not use policies as a substitute for the exercise of good judgment as it is recognized that a guideline may not be uniformly appropriate.

If you have a specific question that is not addressed by this policy or if you have questions about the application of this policy, please contact a supervisor, the compliance officer, or legal department.

Approved:

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Signature

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