Policy Statement

It shall be the policy of St. Joseph's/Candler Health System (SJ/C) to bill and collect for services rendered compliantly according to federal regulations. It will further be the policy of SJ/C to make reasonable efforts to determine whether an individual is eligible for assistance under its **Financial Assistance (FAP) (Administrative Policy #1220-A)** before engaging in Extraordinary Collections Actions (ECA), as specified herein.

This policy does not affect or limit SJ/C's dedication and obligation under EMTALA to treat patients with emergency medical conditions.

SJ/C will engage in the billing and collections policy described herein without regard to the patient's race, color, religion, creed, sex, national origin, age, disability, gender identity or expression of such person, or any other classification prohibited by law.

The billing and collections policy contained herein is applied consistently to all emergency and other Medically Necessary care provided by SJ/C at the following facilities:

- St. Joseph's Hospital
- Candler Hospital
- SJ/C Medical Group (Medical Group)
- SJ/C Oncology Services (Oncology Services)
- SJ/C Home Health Services

Entities to whom this Policy Applies

St. Joseph's Hospital, Candler Hospital, SJ/C Medical Group (a listing of SJ/C Medical Group can be found on the SJ/C website at https://www.sjchs.org, SJ/C Oncology Services and SJ/C Home Health Services.

Entities to whom this Policy Does Not Apply

The Providers, including provider groups, that are not covered by the Policy include Chatham Radiologists, Georgia Emergency Physicians, Pathology Associates, Coastal EMS, Southside Fire/EMS Ambulance Service, SemperCare, Candler Retail Pharmacy, American Anesthesiology Associates of Georgia, and any LIP with admitting privileges that is not listed as part of the SJ/C Medical Group.

Definition of Terms

Amounts Generally Billed (AGB) – The amount by which charges for Uninsured patients are measured. Uninsured patients will not be charged more for emergency or other Medically Necessary care than the AGB for patients who have insurance coverage. To calculate AGB, SJ/C uses the look-back method inclusive of both hospital facilities' experience. The look-back method utilizes data from Medicare and private health insurers based on the prior 12-month fiscal year to determine the AGB percentage applied. The AGB percentage utilized by SJ/C and the method in which it was determined is available free of charge from the Customer Service Department. Customer Service may be contacted at 912-819-8455 or 800-374-7054.

Centralized Billing Office (CBO) – SJ/C co-workers who complete patient billing and collections on behalf of SJ/C employed LIPs.

Discount - A reduction of the patient account balance (up to 100% of Gross Charges).

Extended Business Office – Any extension of the SJ/C Business Office that could be an associated company, outside vendor, or partner that helps deliver on any Revenue Cycle function.

Extraordinary Collection Actions (ECA) - Any actions taken by the SJ/C (or any agent of SJ/C, including a collection agency) against an individual related to obtaining payment of a bill covered under this policy that requires a legal or judicial process, involves selling an individual's debt to another party, or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus. Examples of actions that may require a legal or judicial process include, but are not limited to, placing a lien on an individual's property, foreclosing on an individual's real property, attaching or seizin an individual's bank account or personal property, commencing a civil action, causing an individual's arrest, causing an individual to be subject to a writ of body attachment, and garnishing an individual's wages. Placing an account with a third party for collection is not an ECA.

Federal Poverty Income Guidelines (FPIG) - Determined by the government of the United States and published annually in the Federal Register. FPG are based on the size of a family and family's income. FPG are used in determining a patient's eligibility for financial assistance under Medicaid and SJ/C's FAP.

Financial Assistance Policy (FAP) Discount - A percentage Discount of the patient account balance based on the patient's ability to pay.

Financial Resource Coordinators - SJ/C co-workers who verify proper insurance coverage, secure payment of deductibles and other estimated self-pay balances, aids with patients unable to pay by referral for Medicaid or other state programs, and provide guidance with the FAP.

Gross Charges - Full, established price for medical care that SJ/C entities consistently and uniformly charges all patients before contractual allowances, Discounts or other deductions.

Insured - The status of a patient with insurance or third-party coverage which pays all or a portion of the patient's Gross Charges for medical services. This category includes those patients covered by a governmental payor such as Medicare, Medicaid, Champus and authorized Veteran's benefits; as well as private payors such as Medicare Advantage, Medicaid managed care organizations, commercial or managed care, auto and worker's compensation.

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.

Medically Necessary – Medical services based upon generally accepted medical practices in light of conditions at the time of treatment which is appropriate and consistent with the diagnosis of the treating LIP and the omission of which could adversely affect the patient's condition. This classification does not infringe or encompass the classification of emergent or the EMTALA laws associated with that designation. If the patient feels that the service ordered requires immediate or urgent treatment, the patient may request review of the order by contacting the Office of Medical Affairs at 912-819-6670 or 912-819-3338.

Presumptive Charity – A Discount applied to the outstanding balance of a patient account based on FPIG information provided by a scoring vendor. This Discount is applied at the end of the active self-pay billing cycle.

Prompt-Pay Discount - A 5% Discount of the insured patient's financial responsibility (including any co-payment or deductible) is given before or at the time of service. The Prompt-Pay Discount is available to Hospital and Oncology Services patients regardless of their ability to pay (this Discount is not available to Medical Group patients). This Discount is an administrative adjustment and is not considered financial assistance.

Scoring Vendor - The software company engaged by SJ/C to provide a financial rating (calculated based on credit bureau information such as assets, mortgage payments, auto loans, credit card debt, and other financial history) for patients. The financial rating is utilized as a factor in determining a patient's ability to pay. SJ/C currently contracts with Experian for this service.

Self-Pay Discount - A percentage Discount of the patient's self-pay account balance based on the patient's Uninsured status. Uninsured Hospital and Oncology Services patients are eligible for a Self-Pay Discount based on the most recent AGB. Uninsured Medical Group patients are eligible for a 85% Self-Pay Discount if paid at time of service regardless of their ability to pay.

Service Area of SJ/C - The Service Area of SJ/C by Zip Code shall be 29901, 29902, 29903, 29904, 29905, 29906, 29907, 29909, 29910, 29914, 29915, 29920, 29925, 29926, 29928, 29931, 29935, 29938, 29940, 29941, 31308, 31321, 31324, 30415, 30450, 30452, 30458, 30459, 30460, 30461, 31302, 31322, 31328, 31401, 31402, 31403, 31404, 31405, 31406, 31407, 31408, 31409, 31410, 31411, 31412, 31414, 31415, 31416, 31418, 31419, 31420, 31421, 31303, 31307, 31312, 31318, 31326, 31329, 29912, 29927, 29934, 29936, 29943, 31301, 31309, 31310, 31313, 31314, 31315, 31320, 31323, 31333, 30414, 30417, 30423, 30429, 31316, 31304, 31305, 31319, 31331, 31327, 30424, 30446, 30449, 30455, 30467, 30420, 30421, 30427, 30453, 30438, 31599, 31545, 31546, 31555, 31560, 31598, 31513, 31515, 31563, 31624, 31642, 31650, 31510, 31542, 31543, 31553, 31566, 31547, 31548, 31558, 31565, 31568, 31569, 30439, 30451, 31537, 31562, 31623, 31630, 31631, 31634, 31512, 31519, 31533, 31534, 31535, 31554, 31567, 30401, 30425, 30448, 30464, 30471, 31002, 31520, 31521, 31522, 31523, 31524, 31525, 31527, 31561, 31532, 31539, 30442, 30822, 30410, 30412, 30445, 30470, 30473, 31516, 31518, 31551, 31556, 31557, 30436, 30474, 30475, 30457, 31501, 31502, 31503, 31550, 31552, 30411, 30428, 31037, 31055, 31083, 31544, 31549.

SJ/C Business Office – A department within St. Joseph's/Candler Health System that manages the financial aspects of patient care from the initial point of contact through to final payment of services. This department manages several functions within the organization including, but not limited to: Registration, Scheduling, Insurance Verification, Authorizations, Charge Capture, Coding, Billing, Payment Posting, Denial Management, Patient Collections, and Accounts Receivable Management.

Soft Inquiry – An inquiry reflective on a patient's credit bureau report, but not reportable to any outside entity, that can only be seen by the patient. This has no impact on a patient's credit score and is allowed by Federal Law due to the provider extending credit to the patient by not requiring the patient to pay upfront for any services the provider may render.

Uninsured (Self-Pay) - The status of a patient without insurance or third-party coverage who does not qualify for Medicaid or other state assistance. A patient may also be classified as "Uninsured" if the patient is Insured, but the insurer refuses to pay for medical services rendered for reasons such as pre-existing conditions, out-of-network provider, or other issues that may result in non-payment from the third party. Patients with access to auto insurance benefits of any kind, worker's compensation, victims of crime funds, etc. will be excluded as well as any patients who refuse or fail to comply with requirements that would allow coverage under a governmental or non-governmental program.

Procedures

FINANCIAL ASSISTANCE BILLING PROCEDURES

A. Hospital FAP Discounts receive the appropriate level of approval, i.e., Manager of Patient Financial Service up to $25,000, the Director of Patient Financial Services or Vice President of Revenue Cycle approve up to $75,000, the Chief Financial Officer those over $75,000, and the President & Chief Executive Officer those over $150,000.

The Director of Physician Revenue Cycle or designee must approve Medical Group and Oncology Services FAP Discounts under $25,000. Oncology Services Discounts over $25,000 must be approved by the Executive Director of the Lewis Cancer & Research Pavilion.

B. Approved Hospital FAP Discounts are processed by Payment/Resolution staff. A notification regarding the level of FAP Discount is provided by mail to the patient. Approved FAP Discounts for the Medical Group and Oncology Services are processed by the SJ/C Financial Counselor who will mail notification to the patient. FAP Discounts are classified by SJ/C as charity care.

C. If an individual qualifies for free care, SJ/C will provide them with a written notification that nothing more is owed. If an individual is FAP-eligible, but qualifies for less than free care, SJ/C must provide them with a billing statement that indicates the amount the individual owes for the care as a FAP-eligible individual and how that amount was determined. It must also state or describe how the individual can get information regarding the AGB for the care.

D. Patients who are denied financial assistance have the right to appeal. Appeals will be submitted to the Manager of Financial Assistance. An appeal will initiate re-evaluation of a financial assistance application. If SJ/C chooses again to deny a patient's request for financial assistance, a patient has the right to ask the Georgia Department of Community Health for approval.

E. To make a reasonable effort to determine FAP eligibility for patients who do not submit applications, SJ/C will request scoring for self-pay account that has been returned by Extended Business Office for placement to a bad debt collection agency. By requesting scoring, a Soft Inquiry will be placed on the patient's credit bureau report. This scoring will be used as proof of eligibility for Presumptive Charity. The Discount percentage will be based on the Hospital's sliding fee scales. Balances that do not qualify for a Discount will be referred to a collection agency.

F. The placement of a Presumptive Charity adjustment on the account does not prevent an account from being placed with a bad debt collection agency. A notification will be sent to the patient of this additional Discount along with the summary FAP. The patient will be given 30 days in which to submit a financial assistance application with supporting documentation if the patient feels that they might be eligible for a greater discounted amount.

G. Any patient who falls outside the SJ/C guidelines to receive a Discount or whose financial situation has changed, but still feels that they are unable to pay or set up appropriate payment arrangements, can apply for assistance by completing the financial assistance application and furnishing proof of income. These requests will be considered

on a case-by-case basis. The same authority for approval listed in Section IV (A) above will apply and Customer Service will process the write-off and notify the patient.

H. If a patient receives debt relief under bankruptcy, the account balance is written off and classified as charity. The Hospital uses adjustment codes AWAGEARNER and ABANKRUPTCY. If the account is already in a bad debt status and at the collection agency, the same codes will be used to adjust the account using the Bad Debt Recovery journal. These will be reclassified to charity in the General Ledger.

I. In addition to financial assistance, the Chief Financial Officer may approve an adjustment to a patient account balance based on goodwill, public relations or risk management concerns, so long as there is no intention to influence patient referrals or induce any federal health care program beneficiary to receive services from SJ/C.

FINANCIAL ASSISTANCE BILLING PROCEDURES

A. Insurance coverage for patient accounts is reviewed within one business day of the pre-admission interview or actual admission date. SJ/C attempts to meet managed care pre-certification requirements; however, it is ultimately the patient's responsibility to obtain precertification/referral authorization prior to admittance. SJ/C will not be held liable if a precertification/referral is not properly obtained, unless SJ/C is contractually obligated to obtain the pre-certification/referral.

B. Uninsured patients are screened for eligibility under Medicaid or other state programs as soon after admission as possible. Financial Solution Advisors meet with Uninsured patients in a bed to make payment arrangements and/or to provide information regarding the FAP. Financial counseling is available to all patients to address concerns regarding financial options.

C. Co-payment and deductible and/or estimated co-insurance amounts are requested from Emergency Department patients at the time of discharge. Co-payment and deductible amounts (or estimated amounts thereof) are requested from Inpatient, Observation, Imaging, and Same Day Surgery patients at pre-registration, registration or prior to discharge.

D. It is the patient's responsibility to provide SJ/C with all necessary information to bill the patient's insurance(s). SJ/C staff will complete and submit claims on the patient's behalf. Patients will be billed for balances remaining after third-party payments and adjustments are applied. Even though insurance is carried, the patient is ultimately responsible for providing payment for services rendered. If the patient's insurance rejects or denies payment for services, SJ/C will bill the patient, unless SJ/C is contractually prohibited from doing so in accordance with 501R regulations or as outlined in a contract with a specific third-party payor.

E. The Self-Pay Discount is available to all Uninsured patients regardless of their ability to pay, and is considered financial assistance. If an Uninsured patient receives a Self-Pay Discount and subsequently provides valid insurance information, the Self-Pay Discount will be reversed when SJ/C bills the third party. If an Uninsured patient receives a Self-Pay Discount and subsequently qualifies for financial assistance, the Self-Pay Discount will be reversed before the FAP Discount is applied.

F. Uninsured Hospital patients are eligible for a Self-Pay Discount based on the most recent AGB. This Discount is provided at the time of final billing and is reflected on the first bill. Uninsured SJ/C Medical Group, SJ/C Home Health Services, and Oncology Services (Savannah) patients are eligible for an 85% Self-Pay Discount. This Discount will be processed by the Practice Manager or designee at the time charges are processed or reviewed.

G. All Hospital patients, who are insured, are eligible for a 5% Prompt-Pay Discount if they pay in full before or at the time of service. Prompt Pay Discounts are classified as administrative adjustments.

H. Billing functions for self-pay balances are performed by SJ/C's Business Office. The patient billing cycle begins with the production of a final bill (in the case of Uninsured patients) or with payment or denial by the insurer (in the case of Insured patients). The billing cycle is as follows:

Day 5 – 1st statement
Day 30 – 2nd statement
Day 60 – 3rd statement
Day 90 – Final notice
Day 121 – Returned to SJ/C and referred to collection agency or written off as Presumptive Charity based on financial rating from Scoring Vendor on final statement.

Outbound calls are placed throughout the billing cycle. The availability of financial assistance is on all billing statements.

I. SJ/C's Business Office also establishes and monitors patient payment plans according to the following guidelines:

Account Balance	Maximum Number of Monthly Payments
$1,000 - $3,000	12
$3,001 - $6,000	24
$6,001 - $9,000	36
$9,001- $12,000	48

Statements are provided on a monthly basis to patients on approved payment plans.

Any and all exceptions to the above procedure (up to $25,000) must be approved by the Manager of Patient Accounts, Manager of Patient Financial Solutions, the Supervisor of Customer Service, Director of Patient Financial Services or Vice President of Revenue Cycle (for patient account balances of up to $75,000) or the Chief Financial Officer (for patient account balances of $75,000 and above).

J. Accounts with patient balances greater than $10,000 may qualify for a "catastrophic adjustment" if the patient does not otherwise qualify under SJ/C's financial assistance policy (FAP). This adjustment plan may be applied to balances after insurance or if greater than the standard Uninsured discount of 85%. In order to receive this adjustment, the patient must formally set up a payment plan that equals 20% of the patient's disposable income over the twenty-four months. During the timeframe of the catastrophic adjustment plan, any new balances will be adjusted. If the patient's income changes or the patient defaults on the payment plan, the patient's balance will be evaluated and the discount may be reversed.

K. Patient concerns/inquiries are handled by the Patient Accounts Customer Service staff. Any unresolved patient concerns are referred to the Customer Service Team Leader, Customer Service Supervisor. Manager of Patient Financial Solutions, or Patient Accounts Manager. If questions regarding patient charges arise, the manager of the clinical department and the Revenue Integrity department are consulted. If there is a material dispute regarding the charges on the patient's bill, the collection process may be put on hold until the dispute is resolved. Write-offs done as resolution to a patient concern or patient care issue must be approved by the Manager of Patient Financial Services (up to $25,000), the Director of Patient Financial Services or Vice President of Revenue Cycle or Director of Risk Management (up to $75,000), the Chief Financial Officer ($75,000 to $150,000) and the President/Chief Executive Officer ($150,000 or more).

NON-PAYMENT

Patient accounts for which no payment has been received and financial assistance has not been requested, and the patient is not eligible for financial assistance as otherwise confirmed by SJ/C pursuant to the FAP, are referred to a collection agency 120 days after the patient's first post-discharge bill is produced. A billing statement for care is considered "post-discharge" if it is provided to an individual after the patient received care, whether inpatient or outpatient, and the individual has left the hospital facility. Patients whose accounts have been referred to a collection agency are still able to request financial assistance [at any time] or [up to 240 days after the first post-discharge bill is provided].

SJ/C requires the approval of the Director of Patient Financial Services or Vice President of Revenue Cycle to engage in an "extraordinary collection action" (ECA) with the exception of reporting to the credit bureaus on a patient account. The Director or Vice President has the final authority and responsibility for determining whether SJ/C made reasonable efforts to decide whether a patient is FAP-eligible prior to engaging in ECAs.

The Director or Vice President will confirm the following actions were taken with regard to a patient prior to approving ECAs on the patient's account:

- The patient received the notice of an ECA no earlier than 120 days after first billing and has not responded to any invoice or notice seeking financial assistance;
- The notice of a potential ECA specified the potential ECA(s) that would be taken if the patient did not submit a completed financial assistance application or pay the amount due by the deadline (which must be specified in the notice);
- The potential ECA notice was provided to the patient 30 days prior to the ECA deadline;
- SJ/C has made a reasonable effort to provide oral notification about the FAP and how the individual may obtain assistance with the FAP application process at least 30 days before first initiating one or more ECAs to obtain payment for the care.

The Director or Vice President will also inspect the patient's billing file prior to approving ECAs on the patient's account. The Director or Vice President will confirm the following communications with the patient are noted in the billing file:

- A plain language summary application for financial assistance was provided before discharge;
- All billing statements and other billing communication were provided in plain language;
- Any oral communication, or attempts, with the patient provided financial assistance information in plain language; and
- At least one notice of potential ECAs was provided to the patient.

The collection agency is authorized by SJ/C to take the following ECAs to obtain payment of a patient bill. The collection agency is not authorized to pursue these ECAs at any time SJ/C itself would be prohibited from pursuing ECAs:

- Placing a lien or foreclosing on an individual's property;
- Attaching or seizing individual's bank account or any other personal property;
- Garnishing wages; or,
- Filing a civil lawsuit.

RECEIPT OF APPLICATION AFTER BILLING AND COLLECTIONS PROCEDURES ARE INITIATED.

If the patient submits an application for financial assistance after the patient's account has been referred to a Collections agency or after any ECA has been initiated, the patient's eligibility for financial assistance will be reviewed under SJ/C's FAP. SJ/C will make reasonable efforts to determine if the individual is FAP-eligible, including taking the following actions:

- Suspending any ECA taken against the individual (and/or notifying the collections agency to do the same) until the individual's FAP-eligibility has been determined.
- Making an eligibility determination under the FAP; and

- Notifying the individual in writing of the FAP-eligibility determination and the basis for the determination.

If any individual is determined to be FAP-eligible, the hospital will refund any excess payments for medically necessary services over $5.00 made by the FAP-eligible individual for the care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual and will take steps to reverse any ECA taken against the individual to obtain payment for the care.

Approved:

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Reviewed: 06/26
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Rescinded:
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Printed copies are for reference only. Please refer to the electronic copy for the latest version.