GP.01	TANNER MEDICAL CENTER, INC
TITLE:	**Billing, Charging and Collection Policy**
FORMULATED BY:	**Patient Financial Services/Compliance**
APPLIES TO:	**Tanner Medical Center, Carrollton** **Tanner Medical Center, Villa Rica** **Higgins General Hospital**
EFFECTIVE: **7/98**	**REVIEWED: 8/98, 11/03, 10/04, 2/10, 01/18, 06/19, 09/19** **REVISED: 7/00, 11/12, 09/19**
REQ/REG BY: IRS Department of Community Health, IRS 501c(3) and 501r IRS.gov/pub/irsdrop/reg-13026611.pdf	**REFERENCE:**

PURPOSE:

To provide for fair and equitable billing and charging practices to all patients and to ensure all compliance regulations and requirements are met. To inform the patient population of the billing, charging and collection policies by means of written notification at time of service, and to follow established guidelines by IRS Proposed Regulations regarding Patient Financial Assistance Program (PFAF) notifications and Extraordinary Collection Act (ECA).

POLICY:

It is the policy of Tanner Health System and the Patient Financial Service Department that all billing, charging and conflict/dispute resolutions will be conducted in a fair and equitable manner. Insurance, when provided, will be billed in a timely manner and follow up steps taken to insure payments and adjustments are made correctly. Patients will not be discriminated against, or given preferential treatment based on race, religion, age, national origin, gender or ability to pay.

1. **Insurance Acceptance and Billing Policy**

Insurance assignment will be accepted in lieu of cash payment at the time of service for up to the verified amount of benefits. Insurance billing services shall be provided for all insurance policies the patients may wish to assign to the hospital, up to the number required to fully satisfy the patient's financial obligation to the hospital. This service shall be provided fairly and equitably without regard to age, race, gender, religion or national origin. Billing assistance will be provided for additional policies as time permits. The billing staff will follow and abide by all requirements of the insurance carrier relating to contracts agreed upon by Tanner Health System. Special requirements from other type insurance carriers will also be followed to the best of THS staff's ability.

2. **Self-Pay Billing and Collection Policy:**

It is the policy of Tanner Health System that patients will be offered a 20% Prompt Payment Point of Service Discount on the self-pay portion of account. All uninsured self-pay patients will receive an initial 60% discount of total charges at time of final bill. Every reasonable effort will be made to collect any amounts known to be due from the patient or responsible party prior to service. Purely cosmetic and elective type services shall be available on a cash basis, and payment of the specified deposit must be received in advance of service.

3. **Charging Policy:**

Tanner Health System shall not maintain separate and different charge masters for insured and uninsured patients; nor shall separate charge masters be maintained for patients covered by Medicare, Medicaid, or other federal or state programs. Final bills to patients may be adjusted based on agreements negotiated with HMO, PPO or other managed care programs. Patients will only be charged for services that have been ordered and provided.

4. **Access to Charity/Indigent Care Policy:**

Access to Charity/Indigent programs at any time during the process is provided to patients. Approval or disapproval will be based solely upon the patient's need and demonstrated inability to pay. Demonstration of need can be achieved by completing the charity application and providing the required proof of income and other needed information. The levels of charity available are predicated

on income and family size as specified to current Charity/Indigent guidelines. These are taken from the Federal Poverty Guidelines and update as required. Presumptive financial assistance may also be available in certain situations.

5. Conflict & Dispute Policy:

It is the desire of Tanner Health System to gather, investigate and fairly resolve any and all conflicts or disputes with patients, guarantors or insurance carriers. Appropriate steps will be taken to make any corrections if found to be necessary or to have on hand supporting documentation to justify when action will not be taken. To avoid poor customer service, all request, complaints or questions should be investigated and resolved in a timely manner. This includes but is not limited to: patients, guarantors, insurance carriers and other departments. (Exhibit BOS.07)

Fair collection and billing of all self-pay accounts/uninsured balances procedure:

A system generated uninsured self-pay adjustment equal to 60% of total charges will be applied at the time of the final bill for uninsured 100% self-pay patients. Several methods of payment are available to patients who have no insurance or who are expected to have balances remaining after insurance payment.

1. For the convenience of our patients, payments can be accepted by the following methods:
    - Cash
    - Check
    - Visa
    - Discover
    - Master Card
    - American Express

2. Every effort should be taken to obtain balance in full, however, if payment in full cannot be obtained, other possible payment options should be investigated. Hospital financing is the method of last resort and should only be offered after other means of payment have been ruled out.

3. During the interview process, it may be determined that the patient/guarantor is not financially able to pay for the services rendered. At this time, the patient/guarantor should be made aware of the PFAP (Patient Financial Assistance Program) and necessary steps taken to screen. If patients are qualified for one of the Tanner Assistance Programs, the 60% uninsured adjustment will be reversed, and the full balance considered for that program.

4. Patients who are unable to pay or refuse to pay at or before the time of service, or make alternative arrangements will receive regularly scheduled statements, letters or phone calls from the Patient Financial Services Department and/or its contracted billing/collection service for collecting outstanding account balances. PFAP information will be provided as part of each statement and collection letter sent to patients for collections.

5. Tanner will follow established IRS Proposed Regulations relating to ECA's (Extraordinary Collection Action). Any actions taken by the facility against an individual related to obtaining payment of a bill.

   Examples of ECA's are:
   a. Placing a lien on property
   b. Commencing a civil action against an individual
   c. Garnishing an individual's wages
   d. Reporting adverse information about an individual to a credit bureau
   e. Selling an individual debt to another party

6. Before engaging in ECA's, the facility will engage in reasonable efforts to determine whether an individual is FAP-eligible. The following steps will take place before ECA is started:
   a. Patient/guarantor is notified regarding PFAP.
   b. Provides patient/guarantor with information relevant to completing an incomplete FAP application
   c. Determination is made as to whether the individual is FAP-eligible, and documentations is added to patient accounts.

7. Failure to pay during this cycle of collection attempts will result in the account being transferred to a collection agency for intensive collection activity, which can include legal action. Accounts will not be referred to an outside collection agency until all internal efforts have been exhausted and patients have received at least three (3) contacts offering information relating to PFAP guidelines and application process. Patients/guarantors are sent a final notice of the intent to place account with collection agency.

8. Patients identified as having insurance coverage after final bill will have the 60% uninsured discount reversed prior to billing.

9. The notification period for Patient Financial Assistance Program begins on the date of service and ends on the 120th day after the first billing statement. If FAP application has not been submitted by the close of the notification period, the hospital generally may engage a third-party collection agency. However, if the hospital receives a FAP application at any time within 240 days after the first billing statement, it will suspend any ECA's it has started until it has processed the application. If the patient is subsequently deemed FAP-eligible, the hospital will reverse the ECA's and promptly refund any over paid amounts.