BON SECOURS HEALTH SYSTEM

Policy/Procedure

Title:	Billing and Collections	Date:	04/13//2016
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Category:	SYS.FIN.BILL	Approved by: BSHSI Board	

POLICY

It is the policy of Bon Secours Health System, Inc. ("BSHSI") to provide information regarding the billing and collection practices for BSHSI acute hospital facilities. This policy, in conjunction with the Patient Financial Assistance Policy, is drafted with the intention of satisfying the requirements in Section 501(r) of the Internal Revenue Code of 1986, as amended, regarding financial assistance and emergency medical care policies, limitations on charges to persons eligible for financial assistance, and easonable billing and collection efforts and should be interpreted accordingly.

SCOPE

This policy applies to all BSHSI acute care and free standing emergency room facilities. Any collection agency working on behalf of BSHSI will honor and support BSHSI's collection practices as outlined below. Unless otherwise specified, this policy does not apply to physicians or other medical providers, including but not limited to emergency room physicians, anesthesiologists, radiologists, hospitalists, and pathologists.

RATIONALE

The rationale for this procedure is for BSHSI to bill guarantors and applicable third party payers accurately, timely, and consistently with applicable laws and regulations.

BSHSI and any contracted Collection Agency will ensure that services provided are in accordance with all applicable federal, state and local laws, regulations, and rules governing the Services, including the Fair Debt Collection Practices Act (FDCPA). In its agreements with BSHSI, each Collection Agency shall agree to treat all patients, employees and business partners in accordance with the Mission and values of Bon Secours Health System. Further, each Collection Agency shall warrant that it will use best industry practices in performing the Services.

DEFINITIONS

Amounts Generally Billed (AGB) – Amounts Generally Billed means the amounts generally charged to patients for emergency and medically necessary services who have insurance for such services. Charges for patients who are eligible for financial assistance shall be limited to no more than amounts generally billed ("AGB") for such services. These charges are based on the average allowed amounts from Medicare and commercial payers for emergency and other medically necessary care. The allowed amounts include both the amount the insurer will pay and the amount, if any, the individual is personally responsible for paying. The AGB is calculated using the look back method per 26 CFR §1.501(r), which may be amended periodically.
Bad Debt – An account balance owed by a guarantor which is written off as non-collectable.

Collection Agency - A "Collection Agency" is any entity engaged by a hospital to pursue or collect payment from guarantors.

Eligibility Period – The period of time a guarantor is awarded financial assistance.

Extraordinary Collection Action (ECA) - An ECA, according to IRS regulations, is any of the following:

- Selling an individual's debt to another party
- Adverse reporting to credit reporting agencies or credit bureaus
- Deferring, denying or requiring payment before providing medically necessary care due to nonpayment for previously provided care
- Actions that require a legal process, including but not limited to:
    - Placing a lien on property
    - Foreclosing on real property
    - Attaching or seizing a bank account or other personal property
    - Commencing civil action against an individual
    - Causing an individual's arrest
    - Causing an individual to be subject to a writ of body attachment
    - Garnishing an individual's wages

Filing a claim in a bankruptcy proceeding is not an Extraordinary Collection Action.

Guarantor – The patient, caregiver, or entity responsible for payment of a health care bill.

Patient Financial Assistance Program - A program designed to reduce the guarantor balance owed. This program is provided to guarantors who are uninsured and underinsured and for whom payment in full or in part of the financial obligation would cause undue financial hardship.

Patient Responsibility for insured patients - "Patient Responsibility" is the amount that an insured patient is responsible to pay out-of-pocket after the patient's third-party coverage has determined the amount of the patient's benefits.

Patient Responsibility for uninsured patients - The amount a patient is responsible to pay after the local AGB has been applied.

Permitted ECA - Notwithstanding the broad set of activities categorized as ECAs, the only ECA BSHSI shall undertake is adverse reporting to credit reporting agencies or credit bureaus, as necessary.

Third-Party Payer - An organization other than the patient (first party) or health care provider (second party) involved in the financing of personal health services

Underinsured - An individual who has insurance but is billed total charges for non-covered services according to their benefit plan. Examples include but are not limited to: Medicare self-administered drugs, maximum benefits reached, maternity riders, etc.

Uninsured - Patients who do not have insurance.

PROCEDURE

Itemized Statement
Guarantors may request an itemized statement for their account at any time free of charge.

Disputes
Any guarantor may dispute an item or charge on their bill. Guarantors may initiate a dispute in writing or over the phone with a customer service representative. If a guarantor requests documentation regarding their bill, staff members will use reasonable efforts to provide the requested documentation to the guarantor within three business days.

Billing Cycle
BSHSI's billing cycle begins from the date of the first statement and ends 120 days after that date. During the billing cycle guarantors may receive calls, statements and letters. Calls may be placed to the guarantor throughout the billing cycle. Below is the schedule of statements and letters:

- A statement is sent to the guarantor when a balance is determined to be owed by the guarantor
- A follow-up letter is sent 30 days after the date on the statement informing the guarantor that their account is past due
- A second letter is sent 30 days after the first letter informing the guarantor their account is delinquent
- A third and final letter is sent 30 days after the second letter informing the guarantor that their account is seriously delinquent and the account may be turned over to a collection agency
- At day 120 of the billing cycle a guarantor's account is placed with a primary collection agency. The primary collection agency will notify the patient via a billing statement 30 days in advance of the specific ECA(s) they intend to initiate. The statement will also include the deadline after which such ECA(s) will be initiated and will include a plain-language summary of the financial assistance policy.

Each statement and letter used in our billing cycle contains information regarding payment methods, payment options, financial assistance website, and a contact number for customer

service.