Banner Health

POLICY and PROCEDURE

TITLE: Patient Financial Services: Billing and Collections Policy for Self-Pay Accounts			
Number: 14344		**Version: 14344.2**	
Type: Administrative		**Author: David Bixby**	
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Facility: System			
Population (Define): All Employees			
Replaces: 12910			
Approved by: Board of Directors			

TITLE: *Patient Financial Services: Billing and Collections Policy for Self-Pay Accounts*

I. Purpose/Expected Outcome:

A. To set forth the actions that Banner Health and Banner Medical Group/Banner Medical Group Colorado (collectively, "BH") will take in the event of non-payment of the portion of patient accounts for inpatient or outpatient hospital services, post-acute facility services, Banner Medical Group services, and home health and hospice services, that are the responsibility of the individual patients and not covered by insurance or other third-party payment source.

B. To ensure that reasonable efforts are made to determine whether the individual responsible for payment of all or a portion of a patient account is eligible for assistance under the Basic Financial Assistance Program and the Enhanced Financial Assistance Program prior to commencement of extraordinary collection actions to collect the account.

C. This policy covers billing and collection for self-pay accounts for both uninsured patients and patients with insurance, including co-payments, co-insurance and deductibles. This policy does not cover actions to be taken to enforce any statutory lien that may exist in favor of BH with respect to the proceeds of any third party recovery to which the patient may be entitled.

II. Definitions:

A. All-Hospital Plain Language Summary means a written statement that notifies an individual that BH offers financial assistance under the FAP for inpatient and outpatient hospital services and contains the information required to be included in such statement under the FAP. Because the Single Patient Account may include services received at different BH facilities and sites, the Plain Language Summary will not contain hospital-specific information. A template for the All-Hospital Plain Language Summary is attached as Appendix A.

B. Amounts Generally Billed (AGB) means the Usual and Customary Charges for Covered Services provided to individuals eligible under the Basic Financial Assistance Program, multiplied by the Hospital-Specific AGB Percentage applicable to such services.

C. Application Period means the period during which BH must accept and process an application for financial assistance under the FAP. The Application Period begins on the date the care is provided

and ends on the 240th day after the BH provides the first post-discharge billing statement or, for patients determined to be presumptively eligible, within a reasonable period of time.

D. Billing Deadline means the date after which BH may initiate an ECA against a Responsible Individual who has failed to submit an application for financial assistance under the FAP. The Billing Deadline must be specified in a written notice to the Responsible Individual provided at least 30 days prior to such deadline, but no earlier than the last day of the Notification Period.

E. Completion Deadline means the date after which BH may initiate or resume an ECA against an individual who has submitted an incomplete FAP if that individual has not provided the missing information and/or documentation necessary to complete the application. The Completion Deadline must be specified in a written notice and must be no earlier than the later of (1) 30 days after BH provides the individual with this notice; or (2) the last day of the Application Period.

F. Extraordinary Collection Action (ECA) means any of the following actions against an individual related to obtaining payment of a Self-Pay Account:

1. That requires a legal or judicial process;
2. Involves selling of a Self-Pay Account to another party;
3. Reporting adverse information about the Responsible Individual to consumer credit reporting agencies or credit bureaus; and
4. Deferring or denying, or requiring an upfront payment before providing Medically Necessary services because of an individual's nonpayment for previously provided Medically Necessary services by the Hospital (unless the upfront payment would have been required under BH policy even if there were no unpaid outstanding accounts).

ECAs do not include: (a) any action to perfect the statutory lien on claims of liability or indemnity granted to health care providers under A.R.S. §33-931 on the proceeds of a judgment, settlement or compromise owed to an individual as the result of personal injuries for which the Hospital provided care; or (b) claim filed in a bankruptcy proceeding.

G. FAP-Eligible Individual means a Responsible Individual eligible for financial assistance under the FAP without regard to whether the individual has applied for assistance.

H. Financial Assistance Policy (FAP) means Banner's Financial Assistance Program for Uninsured Patients Policy, which includes eligibility criteria, the basis for calculating charges, the method for applying the policy, and the measures to publicize the policy, and sets forth two financial assistance programs available to uninsured patients: (1) the Basic Financial Assistance Program, and (2) the Enhanced Financial Assistance Program.

I. Hospital-Specific Plain Language Summary means a written statement that notifies a patient and applicable Responsible Person that BH offers financial assistance under the FAP for inpatient and outpatient hospital services provided at the BH hospital from which the patient is being discharged and contains the information required to be included in such statement under the FAP and is specific to the hospital from which the patient has received services. A template for the Hospital-Specific Plain Language Summary is attached as Appendix B to the FAP.

J. Medically Necessary means those services required to identify or treat an illness or injury that is either diagnosed or reasonably suspected to be Medically Necessary taking into account the most appropriate level of care. Depending on a patient's medical condition, the most appropriate setting

for the provision of care may be a home, a physician's office, an outpatient facility, or a long-term care, rehabilitation or hospital bed. In order to be Medically Necessary, a service must:

1. Be required to treat an illness or injury;
2. Be consistent with the diagnosis and treatment of the Patient's conditions;
3. Be in accordance with the standards of good medical practice;
4. Not be for the convenience of the Patient or the Patient's physician; and
5. Be that level of care most appropriate for the Patient as determined by the Patient's medical condition and not the Patient's financial or family situation.

Emergency services are deemed to be Medically Necessary.

K. Notification Period means the period during which BH must notify an individual about its FAP in order to have made reasonable efforts to determine whether the individual is FAP-Eligible. The Notification Period begins on the first date care is provided to the individual and ends on the 120th day after BH provides the individual with the first post-discharge billing statement for the care.

L. PFS means Patient Financial Services, the operating unit of BH responsible for billing and collecting Self-Pay Accounts.

M. Responsible Individual means the patient and any other individual having financial responsibility for a Self-Pay Account. There may be more than one Responsible Individual.

N. Self-Pay Account means that portion of a patient account that is the individual responsibility of the patient or other Responsible Individual, net of the application of payments made by any available healthcare insurance or other third-party payer (including co-payments, co-insurance and deductibles), and net of any reduction or write off made with respect to such patient account after application of the Basic Financial Assistance Program or the Enhanced Financial Assistance Program, as applicable.

O. Single Patient Account means one consolidated statement for Self-Pay Accounts from BH hospitals, physicians, clinics and home health services.

P. Uninsured Patient means a patient without benefit of health insurance or government programs that may be billed for Medically Necessary Services provided to them or for physician services, and who is not otherwise excluded from the Basic Financial Assistance Program or the Enhanced Financial Assistance Program.

III. Policy:

A. Subject to compliance with the provisions of this policy, BH may take any and all legal actions, including Extraordinary Collection Actions, to obtain payment for medical services provided.

B. BH will not engage in ECAs, either directly or by any debt collection agency or other party to which the hospital has referred the patient's debt, before reasonable efforts are made to determine whether a Responsible Individual is eligible for assistance under the FAP. Notwithstanding, BH may engage in ECAs at any time where the Responsible Individual is determined not to be FAP-Eligible.

C. All patients will be offered the Hospital-Specific Plain Language Summary and an application form for financial assistance under the FAP as part of the intake or discharge process.

D. BH may presumptively determine eligibility for the Enhanced Financial Assistance Program based upon previously provided information or information other than that provided by the Responsible Individual. Such information will be obtained by accessing, either directly or using a third-party vendor, information from credit agencies (e.g., Equifax), using the individual's social security number, to determine the individual's annual income and family size, and then comparing such information to the eligibility criteria for the Enhanced Financial Assistance Program.

E. At least one Single Patient Account statements for collection of Self-Pay Accounts shall be mailed to the last known address of each Responsible Individual prior to the end of the Notification Period; provided, however, that a Single Patient Account statement need not be sent after a Responsible Individual submits a complete application for financial assistance under the FAP. A Single Patient Account statement of Self-Pay Accounts will include:

1. An accurate summary of the hospital services and a detail listing of the physicians and home health services covered by the statement;
2. The charges for such services;
3. The amount required to be paid by the Responsible Individual (or, if such amount is not known, a good faith estimate of such amount as of the date of the initial statement); and
4. A conspicuous written notice that informs the recipient of the availability of financial assistance under the FAP and that Banner Patient Financial Services can provide information about the FAP and the application process. Notice shall include the telephone number for Banner Patient Financial Services (480-684-7409 or, if outside Arizona, 855-244-7460) and the Banner Web page where copies of FAP documents may be obtained.

Detail itemizations for hospital charges will be provided upon request.

F. At least one Single Patient Account statement sent during the Notification Period will include written notice that informs the Responsible Parties about the specific ECAs that BH intends to take if the Responsible Individual does not apply for financial assistance under the FAP or pay the amount due by the Billing Deadline (i.e., the last day of the Notification Period). Such statement will include the Hospital Plain Language Summary and must be provided to the Responsible Individual at least 30 days before the deadline specified in the statement.

1. In Arizona, the specific ECAs in this notice will ordinarily include (a) sale or transfer Self-Pay Account to collection agency, (b) reporting adverse information about the Responsible Information to consumer credit reporting agencies or credit bureaus, and (c) deferring, denying or requiring an upfront payment before providing non-Emergent Medically Necessary services.
2. In all other states, the specific ECAs in this notice would include all of the Arizona ECAs, as well as the initiation of a lawsuit to collect the Self-Pay Account.

G. For Single Patient Accounts, the Responsible Individual's propensity to pay will be scored and based on the assessment of the Responsible Individual's likelihood to pay and dollar amount of the Self-Pay Account.

H. At least 30 days before the initiation of any ECAs, an attempt will be made to contact Responsible Individuals by telephone at the last known telephone number, During all conversations, the patient or Responsible Individual will be informed about the financial assistance that may be available under the FAP and about the application process.

I. Where a patient has had multiple episodes of care, BH may aggregate the outstanding bills, but may not initiate an ECA until 120 days after it provided the first post-discharge beill for the most recent episode of care included in the aggregation. A separate application period starts with each episode of care.

J. Where a Responsible Individual has completed the FAP application process, BH will make a determination of eligibility in a timely manner and will notify the Responsible Individual of the determination, the assistance available to the patient and the basis of the decision.

K. When a patient is determined to be eligible for the Basic Financial Assistance Program, BH may include a billing statement that indicates how much the patient owes for care, how that amount was determined, and how the patient may obtain information regarding the AGB for care. When a patient is determined to be eligible for the Enhanced Financial Assistance Program, the patient shall be notified in writing of such determination but a billing statement indicating that nothing is owed for care is not required. If an individual who has paid for services is subsequently determined to be FAP-Eligible, the Hospital will refund any amount paid for care that exceeds the amount a FAP-Eligible patient would have paid; however, the Hospital is not required to refund excess payments of less than $5. BH will take all reasonably available measures to reverse any ECA taken to obtain payment for the care.

L. ECAs may be commenced as follows:

1. If all Responsible Individuals fail to apply for financial assistance under the FAP by the last day of the Notification Period, and the Responsible Parties have received the 30-day written notice described in Section III.F above, then BH may initiate ECAs.
2. If all Responsible Persons apply for financial assistance under the FAP, and PFS determines definitively that the Responsible Individuals are ineligible for any financial assistance under the FAP (including because the patient was not uninsured), BH may initiate ECAs.
3. If any Responsible Individual submits an incomplete application for financial assistance under the FAP prior to the Application Deadline, then ECAs may not be initiated until after each of the following steps has been completed:

    a. PFS provides the Responsible Individual with a written notice that describes the additional information or documentation required under the FAP in order to complete the application for financial assistance, which notice will include a copy of the All-Hospital Plain Language Summary.
    b. PFS provides the Responsible Individual with at least 30 days' prior written notice of the ECAs that BH may initiate against the Responsible Individual if the FAP application is not completed or payment is not made; provided, however, that the deadline for completion or payment may not be set prior to the Application Deadline.
    c. If the Responsible Individual who has submitted the incomplete application completes the application for financial assistance, and PFS determines definitively that the Responsible Individual is ineligible for any financial assistance under the FAP, BH may initiate ECAs.
    d. If the Responsible Individual who has submitted the incomplete application fails to complete the application by the deadline set in the notice provided pursuant to Section III.H.3.b above, then ECAs may be initiated.
    e. If an application, complete or incomplete, for financial assistance under the FAP is submitted by a Responsible Person, at any time prior to the Application Deadline, BH will suspend ECAs while such financial assistance application is pending. Where an application is

incomplete, the Responsible Person will be given a reasonable period of time to complete the application at which time, an ECA may be resumed. If the Responsible Person subsequently completes the application, the ECA will be suspended until the hospital determines whether the individual is FAP-Eligible.

M. A letter indicating intent to transfer the Single Patient Account to a collection agency shall be mailed to the last known address of each Responsible Individual prior to transfer of a Self-Pay Account to a collection agency or the initiation of any ECA.

N. Any Responsible Individual, or representative thereof, who contacts PFS for information concerning any possible financial assistance, shall be provided with information concerning the Basic Financial Assistance Program and the Enhanced Financial Assistance Program under the FAP.

O. After the commencement of ECAs is permitted under Section III.H above, external collection agencies shall be authorized to report unpaid Self-Pay Accounts to credit agencies, and to file litigation, obtain judgment liens and execute upon such judgment liens using lawful means of collection; provided, however, that prior approval of PFS shall be required before lawsuits may be initiated in Arizona, and prior approval of PFS shall be required before collection agencies may use any means of collection that involves physical detention or arrest of any Responsible Person.

P. Patients who are able, but unwilling, to pay for BH services are considered uncollectible bad debts and will be referred to outside agencies for collection. Patients who qualify for either the Basic Financial Assistance Program or the Enhanced Financial Assistance Program and who fail to pay the balance when due, after application of the appropriate discount, are considered uncollectible bad debts for the amount of such balance and will be referred to outside agencies for collection.

Q. Copies of this policy are available free of charge to the public. Copies of the policy are available in each hospital's admitting areas and emergency department, and on the BH internet (www.bannerhealth.com/_Patients+and+Visitors/Financial+Services/Financial+Assistance) and may be requested by mail. The policy is published in English, Spanish, and languages of any other population with limited English proficiency that constitutes more than 5% or 1,000 residents of the community served by the Hospital, whichever is less.

R. If BH refers or sells a Self-Pay Account to another party during the Application Period, the written agreement with such party must obligate such party to:

1. Refrain from engaging in ECAs either prior to or after the Billing Deadline;
2. Not charge interest on the debt in excess of the Federal Short-Term Interest Rate plus 3 percentage points;
3. Return the Self-Pay Account to BH upon a determination that the Responsible Party is FAP-Eligible;
4. If the Responsible Individual is determined to be FAP-eligible, ensure that the individual does not pay and is not obligated to pay more than required under the applicable FAP.

S. A Hospital may require a deposit from an Uninsured Patient prior to providing Medically Necessary services, except that no deposit may be required prior to providing emergency services. A Hospital may not, however, deny or require a payment before providing Medically Necessary care because of an Uninsured Patient's nonpayment of a bill for previously provided Medically Necessary services. When requesting a deposit, Patient Financial Services must notify Uninsured Patients of the availability of financial assistance and, upon request, provide a copy of the FAP application form. If

an application is submitted, it must be processed on an expedited basis. Unless an Uninsured Patient has been definitively determined not to be FAP-Eligible, the deposit may not exceed AGB.

T. BH must report on Form 990 whether and how reasonable efforts were made to determine FAP-eligibility before engaging in ECAs.

IV. Procedure/Interventions:

A. N/A

V. Procedural Documentation:

A. N/A

VI. Additional Information:

A. N/A

VII. References:

A. Patient Protection and Affordable Care Act, Sec. 9007
B. Internal Revenue Code, Section 501(r)
C. C.R.S. 25-3-112 (Colorado SB 12-134)
D. 29 C.F.R. §1.501(r)-1 through §1.501(r)-7
E. Notice 2015-46, Internal Revenue Bulletin 2015-28 (July 13, 2015)
F. 79 Fed Reg 78954-79016
G. Colorado Revised Statutes § 25-3-112

VIII. Other Related Policies/Procedures:

A. Financial Assistance Programs for Uninsured Hospital Patients (#14343)
B. Installment Payment Arrangements (#3091)
C. Physician Practices/Clinics: Financial Assistance Program for Uninsured Patients – Physician Billing/Home Health (#11675)

IX. Keywords and Keyword Phrases:

A. Charity Care
B. Financial Assistance Program
C. Collection
D. Billing
E. Self-Pay

X. Appendix:

A. APPENDIX A: Summary of Financial Assistance Programs at Banner Health Hospitals (All-Hospital Plain Language Summary)

APPENDIX A
SUMMARY OF FINANCIAL ASSISTANCE PROGRAMS AT BANNER HEALTH HOSPITALS

All hospitals owned or operated by Banner Health, including the one(s) where you received your care, offer a Basic and an Enhanced Financial Assistance Program to uninsured patients. An uninsured patient is someone who does not have any health coverage at all, whether through insurance or any government program, and who does not have any right to be reimbursed by anyone else for their healthcare expenses.

If you are an uninsured patient, you will qualify for the Basic Program if you have an annual household income of less than $125,000 and lack any other assets to pay the full charges of the hospital where you received your care. If you qualify for the Basic Program, you will be charged "Amounts Generally Billed," which is based upon the average of the amounts that would have been paid to the hospital by private health insurers and Medicare (and co-pays and deductibles)for the medically necessary services that you receive, if you had been insured .

If you are an uninsured patient, you will qualify for the Enhanced Program (1) if you have an annual household income equal to or less than 200% of the Federal Poverty Level and lack other assets to pay the Hospital's full charges and, (2) if requested to do so by the hospital, you apply for Medicaid/AHCCCS, fully cooperate in the application and determination process, and are denied Medicaid/AHCCCS coverage. If you qualify for the Enhanced Program, emergency services will be provided to you free of charge. You will be charged for other medically necessary services at the Amounts Generally Billed (see above).

If you qualify for either the Basic or the Enhanced Programs, you will in no case be charged more than Amounts Generally Billed for emergency services or other medically necessary services. In addition, you will never be required to make advance payment or other payment arrangements in order to receive emergency services. However, you will be required in most situations to make a substantial advance deposit or other payment arrangements based upon an estimate of the Amounts Generally Billed in order to receive non-emergency services.

A free copy of the hospital's financial assistance policy, the billing and collections policy, and the application forms are available on the Banner website at www.bannerhealth.com/_Patients+and+Visitors/Financial+Services/Financial+Assistance. Copies are available are also available by mail by contacting Banner Patient Financial Services at 480-684-7409 or, if outside Arizona, 855-244-7460.

The Banner Patient Financial Services staff is available to answer questions and provide information about the Basic and Enhanced Programs, the application process and nonprofit organizations and government agencies that can assist with these applications. The Banner Patient Financial Services staff are located in the hospital's Admitting area and can be reached by phone at 480-684-7409 or, if outside Arizona, 855-244-7460.Spanish translations of this Summary, the Hospital's financial assistance and billing policies, and the applications forms are available on the Banner (www.bannerhealth.com/_Patients+and+Visitors/Financial+Services/Financial+Assistance) and Hospital websites and in the hospital's Admitting area. They may also be requested by contacting the Banner Patient Financial Services staff at 480-684-7409 or, if outside Arizona, 855-244-7460.

Please note that this Summary only applies to inpatient and outpatient hospital services, and that a different financial assistance policy applies to other healthcare services received from Banner Health, including post-acute services such as home care, and from Banner Medical Group, including physician services. For more information on the financial assistance programs available for non-hospital and physician services, please contact Banner Patient Financial Services staff at 480-684-7409 or, if outside Arizona, 855-244-7460.