CONE HEALTH

Policies and Procedures

Policy Title: Billing and Collections Policy			
Department Responsible: Revenue Cycle	**Policy Code:** OP-REV-2016-207	**Effective Date:** February 5, 2016	**Next Review/Revision Date:** February 1, 2019
Title of Person Responsible: Vice President, Revenue Cycle	**Approval Council:** Finance Committee, Board of Trustees		**Date Approved by Council:** January 25, 2016

PURPOSE:
Cone Health seeks to allocate available financial resources effectively to reduce the cost of health care services for those patients within the community, who are most in need, consistent with their respective legal obligations. This policy recognizes the financial resources of Cone Health are limited; and that Cone Health has a fiduciary responsibility to bill and collect appropriately for patient services. Cone Health does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual preference, age, or disability in their policies, or in the application of their policies, including the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, eligibility status determinations, or in their billing and collection practices.

Cone Health recognizes the cost of necessary health care services can impose a financial burden on patients who are uninsured or underinsured and has acted to lessen that burden for patients. Cone Health also recognizes the billing and collection process is complex and has implemented procedures to make the process more understandable for patients; and to inform patients about discount and financial assistance options.

Consistent with these commitments Cone Health maintains a billing and collection policy that complies with applicable state and federal laws and regulations. This policy describes the financial assistance and discount programs as well as the billing, payment and collection processes applicable to services provided to patients. The policy addresses only those programs and processes applicable to patients (and patient guarantors) and not third party payers. The policy is developed to ensure compliance with applicable regulations required under (1) the Centers for Medicare & Medicaid Services Medicare Bad Debt Requirements (42 CFR § 413.89), (2) the Medicare Provider Reimbursement Manual (Part I, Chapter 3), and (3) the Internal Revenue Code Section 50 I (r).

DEFINITIONS:
Financial Assistance Program: (FAP) A program intended to assist low-income patients who do not otherwise have the ability to pay for their health care services. Such assistance should take into account each individual's ability to contribute to the cost of his or her care. Consideration is also given to patients who have exhausted their insurance benefits and/or who exceed financial eligibility criteria but face extraordinary medical costs. A financial assistance program is not a substitute for employer-sponsored, individually purchased insurance programs, or publically available financial assistance

Medically Necessary Service: A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act.

Elective: Those services that, in the opinion of a physician, are not medically necessary or can be safely postponed.

Emergency Care: Immediate care which is necessary in the opinion of a physician to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any organs or body parts.

Non-Covered Services: Non-medical services, such as social, educational, and vocational services; cosmetic surgery; self- administered medications.

Primary Care: Primary care consists of health care services customarily provided by general practitioners, family practitioners, general internists, general pediatricians, and primary care nurse practitioners or physician assistants, for purposes of prevention, diagnosis, or treatment of acute or chronic disease or injury, but excludes ancillary services and maternity care services.

Estimate of Patient Liability: An expected out-of-pocket dollar amount provided to the patient based on the patient's specific procedure, attending physician and insurance plan. An estimate should not be interpreted as an exact or final cost.

Bad Debt: Accounts that have been determined to be uncollectible because the patient has been unwilling to pay for their medical care.

Medicare Bad Debt: Medicare deductibles and coinsurance amounts that are non-collectible for Medicare beneficiaries.

Household Financial Income: Household Financial Income as measured against annual Federal Poverty Guidelines includes, but is not limited to the following:

- Annual household pre-tax job earnings
- Unemployment compensation
- Workers' Compensation
- Social Security and Supplemental Security Income
- Veteran's payments
- Pension or retirement income
- Other applicable income to include, but not limited to, rents, alimony, child support, and any other miscellaneous source

Third Party Insurers: Any party insuring payment on behalf of a patient to include but not limited to: insurance companies, Workers' Compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, etc., or third-party liability resulting from automobile or other accidents.

Uninsured: Patients who are not covered under an insurance health plan, Workers' Compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, etc., or third-party liability resulting from automobile or other accidents.

Underinsured: Patients covered by a source of third party funding, but at risk of high out-of-pocket expenditures due to their plan benefits package. This may include, but is not limited to, high deductible plans, high coinsurance/copay plans, low per diem policies, etc.

Delivery of Health Care Services

Cone Health evaluates the delivery of health care services for all patients who present for services In the Emergency Department regardless of their ability to pay. The urgency of treatment associated with each patient's presenting clinical symptoms will be determined by a medical professional in accordance with local standards of practice, national and state clinical standards of care, and the hospital medical staff

policies and procedures. It is important to note that classification of patients' medical condition is for clinical management purposes only, and such classifications are intended for addressing the order in which physicians should see patients based on their presenting clinical symptoms. These classifications do not reflect medical evaluation of the patient's medical condition reflected in final diagnosis. Cone Health also complies with the federal Emergency Medical Treatment and Active Labor Act (EMTALA) by conducting a medical screening examination to determine whether an emergency medical condition exists when required by that law. (Emtala Policy # PR ED 2012-63)

Clinical and financial considerations as well as the benefits offered by private insurance or government programs may affect the timing of, or access to, non-emergent or non-urgent health care services (i.e., elective services). Such services may be delayed or deferred based on consultation with the hospital's clinical staff and, if necessary, and if so available, the patient's healthcare provider. Cone Health may decline to provide a patient with non-emergent, non-- urgent services in those cases when a payment source cannot be identified.

For patients covered by private insurance or government programs, patient choices related to the delivery of, and access to, care are often defined in the insurance plan's or the government program's coverage guidelines.

For patients who are uninsured, Cone Health will work with patients to find a Financial Assistance Program that may cover some or all of their unpaid hospital bill(s).
For those patients with private insurance, Cone Health must work through the patient and the insurer to identify what services may be covered by the patient's insurance policy. For patients seeking non-emergent and non-urgent services, it is the patient's responsibility to know what services will be covered prior to seeking care.
For insured patients with very large balances owed after insurance adjudicates, Cone Health offers Hardship Settlements and/or longer-termed payment plans to assist with patient financing needs.

Emergency and Urgent Care Services:

Cone Health complies with Federal EMTALA laws and State Regulations supporting a patient's right to emergency medical treatment. Any patient who comes to Cone Health will be evaluated as to the level of emergency or urgent care services without regard to the patient's identification, insurance coverage, or ability to pay. Additional information is available in the EMTALA policy # PR ED 2012-63

Emergency Level Services include:

Medically Necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e) (1) (B) of the Social Security Act, 42 U.S.C. § 1295dd (e) (l) (B). A medical screening examination and any subsequent treatment for an existing emergency medical condition or any other such service rendered to the extent required pursuant to the federal EMTALA (42 USC 1395(dd) qualifies as an Emergency Level Service.

Urgent Care Services include:

Medically Necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent Care Services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health, but prompt medical services are needed.

Non-Emergent, Non-Urgent Services:

For patients who either (1) arrive at Cone Health seeking non-emergent or non-urgent level care or (2) seek additional care following stabilization of an emergency medical condition, Cone Health may provide elective services after consulting with clinical staff and reviewing the patient's coverage options. Elective Services can be medically necessary services that do not meet the definition of Emergency Level services or Urgent Care Services defined above. Typically, these services are either primary care services or medical procedures scheduled in advance by the patient or by their health care provider (hospital, physician office, other).

Collection of Information on Patient Coverage and Financial Resources
Patient Obligations:

Prior to the delivery of any health care services (except for cases requiring Emergency Level Services or Urgent Care services), the patient is expected to provide timely and accurate information on their insurance status, demographic information, changes to their family income or insurance status, and information on any deductibles or co-payments that are owed based on their existing insurance or financial program's payment obligations. The detailed information may include:

Full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, citizenship, residency information, and the patient's applicable financial resources that may be used to pay their bill;

Full name of the patient's guarantor, their address, telephone number, date of birth, social security number (if available), current health insurance coverage options, and their applicable financial resources that may be used to pay for the patient's bill, and other resources that may be used to pay their bill, including other insurance programs, motor vehicle or homeowners insurance policies if the treatment was due to an accident, worker's compensation programs, and student insurance policies, among others.

It is ultimately the patient's obligation to keep track of and timely pay their unpaid hospital bill, including any existing co-payments and deductibles. The patient is further required to inform either his/her current health insurer (if insured) or the government agency that determined the patient's eligibility status in a government program (if participating) of any changes in family income or insurance status.

Hospital Obligations:

Cone Health will make all reasonable and diligent efforts to collect the patient's insurance and other information to verify coverage for the health care services to be provided. These efforts may occur during the scheduling of services, during pre-registration, while the patient is admitted in the hospital, upon discharge, or during the collection process which may occur for a reasonable time following discharge. This information may be obtained prior to the delivery of any non-emergent and non-urgent

health care services (i.e., elective procedures as defined in this billing and collection policy). Cone Health will defer any attempt to obtain this information during the delivery of any EMTALA level emergency or urgent care services, if the process to obtain this information will delay or interfere with either the medical screening examination or the services undertaken to stabilize an emergency medical condition.

If the patient or guarantor/guardian is unable to provide the information needed, and the patient consents, Cone Health will make reasonable efforts to contact relatives, friends, guarantor/guardian, and the third party for additional information.

Cone Health maintains all information in accordance with applicable federal and state privacy and security laws.

POLICY:

Cone Health generally expects patients or their third party payers to pay in full for services provided. Cone Health will bill third party payers in accordance with the requirements of applicable law, contracts with third party payers or applicable billing guidelines. Patients are also responsible for charges that are not paid by a third party payer within a reasonable time frame or for any balances that exist after payment by the third party payer. Patients who seek services (other than emergency services) may be requested to pay in advance for services that will not be covered by third party payers, including co-payments and deductibles related to covered services. The patient's failure to pay or make satisfactory financial arrangements will render the account delinquent. The hospital reserves the right to take collection actions as permitted by law concerning balances due from either the patient or third party insurers.

Pre Service:

Cone Health is committed to helping patients understand and manage the cost of services they receive before those services are delivered. To help patients prepare for and manage the cost of care they receive, a registration team member may perform pre-service review steps to ensure all information collected is accurate. Accurate information is critical to avoid billing issues and to ensure insurance benefits can be accessed to minimize out-of-pocket expenses.

Before non-emergency services are delivered or **after** emergency conditions have been stabilized, the registration team may perform the following activities:

Validate and Protect Patient Identity – to protect medical and financial information, Cone Health may use commercially available data sources to validate the accuracy of names and addresses. To receive non-emergency services, Cone Health may ask the patient or guarantor for photo ID and may include a copy of your photo ID with your medical record.

Verify Insurance Benefits – based on information provided by patients and guarantors, Cone Health may use our data systems to communicate with insurance companies to verify eligibility and benefits. If insurance information is not provided, Cone Health may check with the major insurance companies and applicable state Medicaid program to check for coverage.

Verify Medical Necessity – not all services are covered by insurance policies. To minimize cost associated with services not covered by insurance Cone Health may verify the appropriateness of pre-service diagnosis and procedure codes so that patients can make an informed decisions about receiving the recommended services.

Obtain Prior Authorizations – If the services to be provided require prior authorization from an insurance company, Cone Health will attempt to secure that authorization from your insurance company. Each patient is responsible for making sure his/her insurance benefits will cover the cost of services to be provided. If Cone Health is unable to obtain proper authorization, patients may be responsible for the cost of services delivered.

Identify Open Bad Debt Accounts – if the patient or guarantor has previously unpaid accounts that have not been enrolled in a payment plan, patients will be asked for payment of these prior services.

Produce an Estimate of Patient Liability – to help patients make informed health care purchasing decisions, an estimate of service costs and patient liabilities may be provided. Cone Health will use all data described in this section to estimate out-of-pocket expenses based on specific insurance benefits, prior authorization requirements and any open prior accounts.

In the event that our registration team is unable to identify coverage for services to be provided, patients may be referred to a financial counselor.

Patients will be asked to pay all or a portion of the estimated co-pays, co-insurance amounts and/or deductible amounts. If the patient is uninsured, a percentage of gross charges will be requested.

Our pre-service financial clearance process is designed to help patients manage unexpected costs associated with health care services. Cone Health also provides payment options to help patients manage balances within their budgets.

Financial Assistance Programs:

Cone Health patients may be eligible for free or reduced cost of health care services through various State Programs, or the Hospital Financial Assistance Program based on the patient's financial circumstances.
Refer to Cone Health Financial Assistance Policy for more detail.

Hardship Settlement:

This program is designed to assist North Carolina and Pittsylvania, Henry and Halifax Counties of Virginia residents who have had a catastrophic medical event regardless of their insurance coverage that has resulted in very large hospital bills in comparison to their financial resources.
Refer to Cone Health Hardship Policy for more detail.

PROCEDURE:
Billing and Collection Process

General:

Cone Health uses the same reasonable efforts and follows the same reasonable process for collecting amounts due for services provided to all patients, including insured, underinsured or uninsured patients. Collection activities may occur during the pre-registration process and will continue until account resolution, a determination the account is uncollectible, or determination of eligibility for financial assistance. The collection process may include requests for deposits, payment plans or discretionary

settlements. The collection process may involve the use of outside collection agencies which may include reporting the outstanding balance to credit reporting agencies. The collection process is documented in the patient's account files accessible to the hospital and its business associates involved in the collections process. (Collection will not, however, be pursued against patients who fall within populations exempt from collection action by law.)

Cone Health will make reasonable and diligent efforts to investigate whether a third party resource may be responsible for the services provided by the hospital, including but not limited to: (1) a motor vehicle or home owner's liability policy, (2) general accident or personal injury protection policies, (3) worker's compensation programs, (4) student insurance policies. In accordance with applicable state regulations or the insurance contract, for any claim where reasonable and diligent efforts resulted in a recovery on the health care claim billed to a private insurer or public program, Cone Health will report the recovery and offset it against the claim paid by the private insurer or public program. If Cone Health has prior knowledge and is legally able, it will attempt to secure assignment on a patient's right to third party coverage (or settlement) on services provided due to an accident. Refer to Credit Balance (Refund) Policy.

Collection Notices:

Cone Health has a fiduciary duty to seek payment for services it has provided from patients who are deemed able to pay. Cone Health reserves the right to utilize outside vendors to assist the facility and patients regarding balances due, process payment plans, etc. When a balance is owed by the patient, the payment is considered "Self-Pay" and payment in full is expected.

An account is determined to be Self-Pay if any of the following are true:

- There is no insurance on record.
- All expected payments from the insurance carriers, Medicare and other third party payers have been paid.
- A patient has not responded timely to requests for information/documentation needed to determine eligibility under Financial Assistance Policies.
- Patient does not provide information requested from third party insurers to process claims

All self-pay accounts process through specific statement cycles.

A Plain Language Summary of the facility's Financial Assistance Policy appears on the back of self-pay patient statements.
Because of the inherent delays and other issues with Medicaid eligibility processes, Cone Health may perform Medicaid eligibility checks on all Self-Pay accounts after discharge. If Medicaid coverage is identified, the account will be reclassified to Medicaid from Self-Pay and billed to Medicaid.

All Self-Pay accounts will be sent a minimum of three statements spanning at least 90 days of time, with the last contact notifying the patient that if the bill remains unpaid, in 30 days they will be referred for additional collection actions.

On any Self-Pay statement, notification is present that an itemized bill can be requested by contacting our Customer Service call center.

Collection activity may include other notification methods that constitute a genuine effort to contact the party responsible for the obligation, including, for example, telephone calls, collection letters, personal contact notices, and computer notifications.

For statements that have been returned as undeliverable, reasonable efforts will be made to determine an accurate mailing address using internal and external tools and resources. These efforts will be documented on each patient account. The detailed policy is available within *Return Mail/Bad Address Policy*.

Additional Collection Activity may include assignment of the account(s) a debt collection agency or Cone Health law firm for legal action.

Documentation of Collection Effort

Patient financial records will be maintained by Cone Health as required by applicable law and in accordance with hospital policies.

Documentation will support billing and collection actions and will include all documentation of the hospital's collection effort including the bills, codes and letter templates, reports of telephone and personal contact, and any other efforts made. Such documentation is maintained until audit review by a federal and/or state agency of the fiscal year Cost Report in which the bill or account is reported or longer if required by law or internal policy. Document Retention Policy # OP-FIN 2009-33

Populations Exempt from Collection Activities:

Patients who are enrolled in a public health insurance program including but not limited to State Medicaid Plans are exempt from billing or collection action after the initial bill pursuant to state regulations subject to the following exceptions:

Cone Health may seek collection action against any patient enrolled in the above mentioned programs for their required co-payments and deductibles that are set forth by each specific program.

Cone Health may initiate billing or collection activities for a patient who alleges that he or she is a participant in a State Program that covers the costs of the services, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in a State Program, (including receipt or verification of signed application), Cone Health shall cease billing or collection activities.

Cone Health may follow the Collections Process for items and services that are excluded from governmental coverage. Non-covered services.

Under the Hospital Financial Assistance Program, Cone Health will cease any collection activity against a patient who has applied for Financial Assistance. If the Financial Assistance Application is incomplete, the patient will be allowed a reasonable period of time to provide missing information. For more information see the Financial Assistance Policy.

Cone Health and their agents shall not continue collection or billing on a patient balances that are part of a bankruptcy proceeding except to secure its rights as a creditor in the appropriate order.

Deposits and Payment Plans:

Patients or their responsible parties are expected to pay their full liability for services rendered within thirty (30) days of receipt of their first bill or in accordance with a mutually agreed upon installment payment plan as described in item 4 in this section.

Cone Health will, to the extent permitted by law, request "pre-admission" or "pre-treatment" deposits equal to 100% of the estimated charges for the services to be provided if the services are: (1) not covered by insurance; (2) elective services (i.e., not Emergency Level Services or Urgent Care Services. Cone Health may require "admission" or "treatment" deposits for other services to the extent permitted by law.

Cone Health may request a deposit from patients eligible for Financial Hardship based on eligibility level.

Cone Health, at a minimum, will offer the following installment plans but may, based on the circumstances, permit repayment with a longer period.

Upon verbal consent between the patient and an authorized hospital agent, payment in the amount of one six of the total patient balance owed, paid in 6 monthly payments.

Extended payment plans are available through an outside vendor. Payment plans are based on account balance and term of contract. Extended contracts could incur an interest charge.

Discretionary Settlements:

Cone Health may choose to settle outstanding accounts based upon extenuating circumstances. These settlements must be approved by Director Patient Accounting, Director Revenue Integrity, VP Revenue Cycle or CFO.

Outside Collection Agencies:

Cone Health contracts with outside collection agencies to assist in the collection of certain accounts, including patient responsibility amounts not resolved after issuance of hospital bills or final notices.

Cone Health has a specific authorization or contract with the outside collection agencies and requires such agencies to abide by the Cone Health Billing and Collection policies for those debts that the agency is pursuing. Cone Health requires any contracted collection agency to follow the regulations and licensing requirements within the States in which the agency conducts business. . Additionally contracted collection agencies must abide by the requirements of the Federal Fair Debt Collection Practices Act.

Minimum Balance:

Cone Health minimum balance write off is less than or equal to $24.99.

Bad Debt Pre-Placement Review
After the initial three contacts and after a period of no less than 120 days from discharge Self-Pay accounts are pre-listed for movement to bad debt. The following actions, if applicable, are then taken:

Accounts are removed if any information has been obtained subsequent to being pre-listed that would indicate the account is collectible.

Primary Bad Debt placement is a process that usually occurs approximately one week after the accounts reach the pre-list status.

Accounts are submitted to a hospital approved primary collection agency. Accounts remain with the primary collection agency for a period of at least 270 days
The primary collection agencies will notify all patients they contact for the purpose of debt collection of Cone Health Financial Assistance policy.

Secondary Bad Debt Placement
Secondary Bad Debt placement occurs after primary placement for all accounts over 270 days in age that have had no payment activity.

The secondary agencies will notify all patients they contact for the purpose of debt collection of Cone Health Financial Assistance policy.

Unpaid accounts stay with secondary agencies for at least 24 months.

Bad Debt Account Recall:

Cone Health will recall accounts from primary and secondary agencies and "clear or clean" the patients file with both the agencies and credit bureaus, if applicable, for the following reasons:

Patient files for bankruptcy
Filing of an estate for the patient
Error by Cone Health that caused the account to improperly be pre-listed (i.e., payment posting error)
Medicare cost Recovery

Annually, Cone Health performs a recall of patient accounts based on the qualifications outlined in the Bad Debt Policy.

Legal Collection Actions:

Legal actions may be taken if an account goes unpaid after Cone Health has exhausted other efforts to collect on the account. Reasonable efforts are made to review every patient's account for financial assistance discounts before legal actions are taken. The hospital's Financial Counseling Department is responsible for determining if an account is eligible for financial assistance. The Cone Health VP Revenue Cycle has final authority in determining when legal actions can take place after accounts are determined to be ineligible for financial assistance. If a patient is found eligible for financial assistance after a legal action has been initiated, legal action will be reversed and financial assistance discounts will be applied. Legal actions are outlined below.
For accounts where patients choose to not cooperate or are not eligible for discounts under hospital's coverage and financial assistance process, or payment plans options, Cone Health reserves the option to refer these accounts for legal collections. Legal action against individuals may be taken only when there is some evidence the patient or responsible party has income and/or assets to meet their obligation or did not cooperate with the hospital in demonstrating financial need. Prior to legal collection placement, all accounts are reviewed for financial assistance eligibility. Only accounts found in-eligible for financial assistance are subject to legal collection placement should the patient fail to pay on the account.

Small Claims Collections – accounts with balances $300 - $5000 may be referred to local County small claims

Lawsuits – Account balances >$5000 may be referred to an attorney for pursuit of judgments according to North Carolina and Virginia Laws.

REFERENCE DOCUMENTS/LINKS:

PREVIOUS REVISION/REVIEW DATES:

Date	*Reviewed*	*Revised*	*Notes*
January 25, 2016			Origination and council approval date.