Reid Health	Department: Revenue Cycle Management
Name: SBO - Billing and Collection Policy	Policy # 7650-SBO-2
Final Approval Date: 05/01/2023	Next Review Date: 05/01/2026
Owner: Julie Morrison (Dir-Revenue Cycle Management)	

I. Policy

Reid Health's (the "Hospital") Billing and Collections Policy (the "Policy") is consistent with the mission and values of the Hospital and considers each individual's ability to contribute to the cost of his/her care, and the Hospital's financial ability to provide the care.

The Hospital has a fiduciary duty to seek reimbursement for services it has provided from individuals who are able to pay, from third party insurers who cover the cost of care, and from other programs of assistance for which the patient is eligible.

Pursuant to Section 501(r)(6) of the Internal Revenue Code of 198, as amended ("Code"), the Hospital does not engage in extraordinary collection actions (ECAs) before the Hospital has made reasonable efforts to determine whether the patient/guarantor is eligible for assistance under the Hospital's Financial Assistance Policy.

As described in more detail herein, in no case will any ECA be undertaken until at least 240 days after the first statement has been sent to the patient/guarantor, regardless of whether the account is in bad debt or assigned to a third-party collection agency.

II. Purpose

The purpose of this Policy is to explain in plain language the Hospital's procedures for billing and collecting balances owed by a patient/guarantor.

III. Definitions

a. Bad Debt - An accounts receivable based on items and/or services furnished to a patient that is deemed uncollectable following reasonable collection efforts pursuant to the Hospital's collection guidelines, is not the obligation of any federal or state agency and is not considered free care.

b. Collection Action - Any activity by which the Hospital or its designated agent requests payment for services from a patient/guarantor. A collection action shall include requesting a pre-admission or pre-treatment deposit, billing statements, collection letters, telephone calls, personal contacts and activities by collection agencies or attorneys.

c. Extraordinary Collection Action (ECA) - Any activity that includes legal recourse such as filing a lien against property; suing patient/guarantor to obtain a judgment; wage garnishment.

IV. GENERAL INFORMATION AND PROCEDURES

A. Prior to Service

1. When scheduling or registering for services, patients are required to provide confirmation of third-party insurance coverage and financial information to determine their ability to pay patient balances incurred because of services provided.

2. Non-emergent or elective services may be delayed if the patient/guarantor refuses to assist the organization by providing necessary information to establish their ability to pay or need for financial assistance. Patients that apply and qualify for the Hospital's

Financial Assistance Program will not be deferred or refused medically necessary services.

3. The provider will be notified during the scheduling process that services may be delayed or rescheduled and given the opportunity to provide additional information about the patient's medical condition and need for immediate attention.

4. If it is determined during scheduling for any non-emergent or elective service that a patient lacks insurance coverage, the patient will be referred to a Patient Financial Navigator or for determining possible coverage under any governmental program or the Hospital's Financial Assistance Program.

B. Discounts

Patients that are true self-pay will receive the following automatic adjustments. These discounts are exclusive to any other discounts or acceptance to the financial assistance policy.

Hospital: Self-pay patients will receive a discount off gross charges. This discount applies to both hospital and hospital physician services. The amount of this discount is consistent with the AGB% and adjusted as appropriate.

Reid Health Physician Associates: For outpatient physician practice services, a 25% discount will be automatically applied and reflected on the guarantor statement. If the balance has not been paid within 60 days, the discount will be removed, and full payment will be expected.

C. Self-Pay

1. When a balance is owed by the patient/guarantor, payment in full is always requested.

2. An initial statement will be sent to the patient/guarantor and will advise that financial assistance is available, including how to contact a Patient Financial Navigator.

3. Statements will be sent in a 30-day incremental cycle for a minimum of four statements, or until the balance is paid. The back of every statement will include how to apply for assistance.

4. Any subsequent billings, statements, telephone calls, collection letters, personal contact notices, computer notifications, or any other notification method constitutes a genuine effort to contact the patient/guarantor for the obligation to resolve outstanding balances.

5. If the patient statement is returned as incorrect address or undeliverable, attempts shall be made to find a better address using all available resources, including Internet resources and standard skip tracing methods.

6. All such efforts to collect, as well as any patient-initiated inquiries shall be documented in the computer billing system and made available for review by any auditing agency or firm.

7. It is a violation of this Policy to engage in any actions which would discourage individuals from seeking emergency medical care, such as demanding that

emergency department patients pay before receiving treatment for emergency medical conditions, or by permitting debt collection activities in the emergency department or in other areas of the Hospital where such activities could interfere with the provision, without discrimination, of emergency medical care.

8. For all self-pay patient accounts, collection activity will cease when a patient has applied for financial assistance until a determination has been made, in accordance with the Hospital's Financial Assistance Policy.

9. A balance on a claim not paid by the third-party insurance company (including third-party liability and worker's compensation) after one year from the date of the first claim will become the responsibility of the patient/guarantor. The Hospital will make every effort to work in good faith with the third-party insurance company to get the claim paid prior to holding the patient/guarantor responsible.

D. Payment Plans

1. In general, payment in full is expected upon receipt of a statement from the Hospital.

2. Patients must contact Patient Financial Services to set up any payment plan, for the account(s) to be properly marked to prevent them from further collection actions.

3. The Hospital offers the following payment plan options:
   - Up to 23 months interest-free internal payment plan.
   - Up to 60 months interest-free with an external health service financing vendor as follows:
     i. 2 years for amounts $3,999.99 or less;
     ii. 3 years for amounts between $4,000 and $6,999.99;
     iii. 4 years for amounts between $7,000 and $9,999.99;
     iv. 5 years for amounts between $10,000 and $50,000

4. It is at the discretion of the Chief Financial Officer and/or Director of Revenue Cycle Management to approve any plan outside of the above, based on patient/guarantor needs and financial situation at the time the contract is negotiated.

E. Third Party Litigation

1. Accounts involving third party litigation that require intervention by legal counsel may be assigned to bad debt status and referred for follow-up.

2. Such accounts may be referred to the Hospital's Chief Financial Officer for approval based on the expected length of time to recover payment and the need for legal counsel.

F. Collection Agencies

1. The Hospital contracts with external collection agencies to assist in the collection of delinquent, unpaid accounts.

2. The Hospital requires such agencies to abide by this Policy for those debts that the agency is pursuing, including the obligation to refrain from ECAs as required under Code Section 501(r)(6).

3. Collection agencies will offer debtors an opportunity to apply for assistance once contact has been made, prior to initiating any ECA, during the period before the 240th day of the first notice to the debtor.

4. Delinquent/bad debt accounts that are referred to collection agencies because the patient/guarantor has failed to cooperate or communicate their financial hardship per the Hospital's Financial Assistance Policy are not eligible for assistance beyond the 240th day after their first billing statement.

5. In no case will any ECA be undertaken until at least 240 days after the first statement has been sent to the patient/guarantor, regardless of whether the account is in bad debt or assigned to a third-party collection agency.

G. Questions

1. Patients or guarantors with questions about their statements/bills should call Customer Service at 765-983-3184 or 855-753-7125 (toll free).

2. All calls will be responded to promptly with referral for proper follow-up as appropriate.

H. How to Obtain a Copy of the Hospital's Collection Policy

This Policy and the Hospital's Financial Assistance Policy with Financial Assistance Application are available free of charge online at the Hospital's website at www.ReidHealth.org. Both policies and the Financial Assistance Application are available for free upon request to:

Reid Health
ATTN: Patient Financial Services Policy Request
1100 Reid Parkway
Richmond, IN 47374

They may also be obtained by calling 800.382.7343, extension 3286.

V. Related Documents

a. Financial Assistance Policy

VI. References

Patient Protection and Affordable Care Act (PPACA), Title IX, Subtitle A, Section 9007(a)(4); Section 501(r)(6) of the Internal Revenue Code of 1986 as amended; §1867 of the Social Security Act (42 USC 1395dd; Centers for Medicare and Medicaid Services Medicare Bad Debt Requirements 42 CFR 413.89.

VII. Approval Process

Julie Morrison, Director Revenue Cycle Management
Chris Knight, Vice President/Chief Financial Officer