Chesapeake Regional Medical Center	Issued By: Patient Financial Services	Policy #: PA0181
	Prepared By: Revenue Cycle Committee	Effective Date: 3/1/2020
Dept: Patient Financial Services	Approved By: Steve McDonnell	Review Date: 3/1/2021
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Policy Title: Billing and Collections Policy		Page 1 of 1

Purpose: It is the policy of Chesapeake Regional Medical Center (CRMC) to provide Emergency Services and other Medically Necessary Services to all patients without regard to the patient's ability to pay, at each CRMC Hospital Facility (as defined below).

In accordance with the Federal Emergency Medical Treatment and Labor Act of 1986 ("EMTALA") and EMTALA regulations, CRMC Hospital Facilities will provide, without discrimination, care for emergency medical conditions regardless of financial assistance eligibility or ability to pay. Patients seeking emergency care are not subject to financial screening prior to receiving care. Additionally, CRMC Hospital Facility will not engage in any actions that discourage individuals from seeking emergency medical care, such as requiring emergency department patients to pay before receiving treatment for emergency medical conditions or permitting debt collection activities in the emergency department or other areas where such activities could interfere with the provision of emergency care on a non-discriminatory basis.

This policy is consistent with CRMC's values of patient-centered care, respect and compassion, quality and service, community health improvement, and financial stewardship in compliance with state and federal laws. CRMC provides, without discrimination, care for Emergency Medical Conditions and other Medically Necessary Services (as defined below) to individuals without regard to such individual's ability to pay or eligibility for Financial Assistance. In determining a patient's indigent or charity status, CRMC considers many factors; such as the patient's income, patient's assets, patient's monthly expenses and patient's liabilities. All uninsured patients automatically receive a 40% discount. The discount may be replaced by the Charity component of the financial assistance policy if it is a greater amount.

The purposes of this policy are to:

Outline CRMC's billing and collections workflow process and policy.

DEFINITIONS

"CRMC" has the meaning set forth above.

"Bad Debt" Any patient financial responsibility that is not in conformance with a payment plan agreed upon by provider and patient or their guarantor or that goes unpaid after provider has attempted to collect the amount due or has made reasonable efforts to determine whether the individual is eligible for financial assistance under the Financial Assistance Policy.

"Collection Agency" A "Collection Agency" is a contracted agency engaged by a CRMC Hospital Facility to pursue or collect payment from patients/guarantors.

"Discounted Care" Discounts applied to gross charges billed to the patient, full or partial waiver of patient financial obligations resulting from medical services provided for patients or their guarantors determined as set forth in the Financial Assistance Policy.

"Eligible Services" means the services (and any related products) provided by CRMC that are eligible for Financial Assistance under this Policy, which shall include:

Emergency Services provided in an emergency room setting.

Non-elective medical services provided in response to life-threatening circumstances that are other than emergency medical services in an emergency room setting,

Medically Necessary Services.

(Cosmetic and other elective packaged plan procedures are exempt from this policy and may fall under separate discounted pricing)

Emergency and other Medically Necessary Services provided within the CRMC Hospital Facility may be provided by the Hospital Facility itself, its employed physicians or independent providers. Services provided by non-employed physicians and independent providers may not be covered under this policy.

"Emergency Medical Conditions" has the same meaning as such term is defined in section 1867 of the Social Security Act, as amended (42 U.S.C. §1395dd). 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 or part or, with respect to pregnant women, as further defined in 42. U.S.C. section 1395dd€(1)(B), or as otherwise defined by applicable law. For example, Emergency Medical Conditions will include, but not be limited to, fainting, difficulty breathing, uncontrolled bleeding, poisoning, or broken or displaced bones.

"Emergency Services" care or treatment provided by a CRMC Hospital Facility for an "emergency medical condition" as such term is defined by EMTALA.

"EMTALA" Emergency Medical Treatment and Labor Act (42 U.S.C. § 1395dd; 42 C.F.R § 489.24).

"Extraordinary Collections Actions (ECA)" reporting adverse information to consumer credit reporting agencies or credit bureaus, legal or judicial activity to include: commencing a civil action against an individual; placing a lien on an individual's property and garnishing an individual's wages.

"Financial Assistance" means any financial assistance in the form of free or discounted care granted to an eligible individual pursuant to the Financial Assistance Policy.

"Financial Assistance Policy" CRMC Financial Assistance Policy #400.11 or version currently in effect.

"Hospital Facility" means a facility that is required by the Commonwealth of Virginia to be licensed, registered, or similarly recognized as a hospital.

"Insured Patient" A patient who has health insurance and does not meet the definition of Underinsured Patient as defined below.

"Medically Necessary Services" shall have the same meaning as such term is defined for Medicare in 42 U.S.C. 1395y(a)(1)(A) (services or items"…reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member…".

"Out of Network" Certain non-contracted insurance plans or third-party administrators may reduce or eliminate the provision of benefits unless care is provided by designated facilities or providers. In cases where provider is not one of the designated facilities or providers or the plan does not have a provider network, any care provided is considered to be out-of-network.

"Provider" A hospital, health system, physician or physician practice owned by a health system.

"Reference-based Pricing" Non-traditional health care coverage where employers set a fixed limit on the amount a plan will pay for certain health care services, there is no written contract with providers, and there is no defined provider network. The provider may decide to accept the fixed amount as payment in full or may bill the patient for the remaining balance.

"Self-Pay Balance" Accounts receivable that patients, or the patient's Guarantors, are obligated to pay directly to the provider. These may include balances due after insurance claims have been paid, amounts due from Uninsured Patients, or balances due after adjustments have been made in accordance with the Financial Assistance Policy.

"Third-Party Coverage" 1) A third-party insurer, 2) an ERISA plan, 3) a federal, state, or local governmental health care program (including without limitation Medicare, Medicaid, SCHIP, and TRICARE), and 4) workers' compensation, medical savings accounts, healthcare cost sharing ministry, or other coverage for any part of the bill, including claims against third parties covered by insurance to which provider is subrogated.

"Uninsured Patient" means a patient of a CRMC Hospital Facility who has no level of health insurance, third party assistance, medical savings account, or claims against third parties covered by insurance to pay or assist with such individual's payment obligations for the provision of eligible services.

"Underinsured Patient" means a patient of a CRMC Hospital Facility who has some level of insurance or third party assistance who nevertheless remains obligated to pay out-of-pocket expenses for the provision of eligible services that exceed such individual's financial abilities and is deemed medically indigent or meets the income and asset requirements as listed on Schedule A, per the Financial Assistance Policy.

"Uninsured Discount" A reduction in charges by the amount determined by the Financial Assistance Policy and the Self-pay Discount Policy Uninsured Patients.

Policy:

Billing and Collection Process

Billing Cycle

CRMC's billing cycle starts from the date of the first statement. Reasonable efforts are made to notify guarantors about our (FAP) by providing information about the CRMC financial assistance program and the application process. During the billing cycle guarantors may receive phone calls, statements and letters regarding the account balance during which time CRMC will assist guarantors with any questions regarding our financial assistance program. The information is available on each billing statement and letters. Information regarding payment methods, payment options, at chesapeakeregional.com under the patients and visitors tab, and a contact number for customer service.

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 may be placed with a collection agency if the guarantor balance is still unpaid and a payment arrangement has not been established or is not in good standing or a financial assistance application has been received. Accounts may also be reported to the Virginia Department of Taxation after a total of 240 days from the date of the first post discharge billing statement if the account does not have payment, established payment arrangements or a financial assistance application has not been received. Submitting a claim to the Virginia Department of Taxation may result in tax debt set-off for seizure of Virginia income tax refunds or lottery winnings for any unpaid balances

Uninsured Discount

All uninsured patients automatically receive a 40% discount. The discount may be replaced by the Charity component of the financial assistance policy if it is a greater amount.

Payment Plans

Self- pay patient balances are eligible to set up payment plans for any self-pay based on the amount of the combined account balances on the following scale.

Account Balance	No interest equal monthly payments
$ 0 - $ 300	Up to 6 months
$ 300.01 to $ 1,000.00	Up to 12 months
$ 1,000.01 to $5,000.00	Up to 24 months
$ 5,000.01 to $10,000.00	Up to 36 months
$ 10,000.01 to $20,000.00	Up to 48 months
$ 20,000.01 >	Up to 60 months

Exceptions to this Policy. The Director of Patient Financial Services and the Chief Financial Officer of CRMC Hospital Facility are each granted the authority to provide payment plan exceptions to this policy on a case-by-case basis as appropriate to an individual patient's facts and circumstances. In no case will a patient be denied a reasonable payment plan.

Disputes

Any guarantor may dispute a charge on their bill. Guarantors may initiate a dispute in writing or over the phone by contacting a customer service representative. A guarantor may request documentation regarding their bill.

Staff members will make reasonable efforts to provide the requested documentation to the guarantor within two business days.

Extraordinary Collection Actions (ECA)

CRMC and its collection agency partners may perform an ECA listed below:

- Reporting adverse information to consumer credit reporting agencies or credit bureaus;
- Legal Actions to include: lawsuit, placing lien on property and wage garnishment for accounts with aggregate balances above $1,000.

Notification of ECA:

- Notify in writing 30 days in advance of an ECA performed by the collection agency partner with the timeframe associated for which the ECA will be initiated
- Provide written notification that financial assistance is available for eligible individuals prior to initiating an ECA.
- ECA's will only be initiated after at least 150 days from the date the Hospital Facility provides the first "post discharge" billing statement for care.
- Provide a copy of the plain language summary of the FAP 30 days prior to initiating ECA.

CRMC's collection agency partners will make a reasonable effort to notify the guarantor about the FAP and how they may obtain assistance. All accounts may have up to 240 days from the date of the initial statement to apply for financial assistance. The Application Period may be longer because CRMC hospital facility must notify a patient (guarantor) at least 30 days before initiating one or more ECAs to obtain payment for the care.

CRMC and its collection agency partners shall not pursue an ECA for a guarantor who has submitted an application for financial assistance. If it is determined the guarantor qualifies for financial assistance and the guarantor has made a payment, CRMC will research to identify if there are other accounts, associated with the guarantor, have any outstanding balance that does not qualify for financial assistance. If an account with an outstanding balance is found, CRMC will contact the guarantor, via letter, informing the guarantor that the payment made on the account, which was approved for financial assistance, will be transferred to the account with an outstanding balance. If the guarantor does not agree to transfer the funds, then any amounts paid will be refunded to the guarantor. If a guarantor qualifies for partial financial assistance the remaining balance will be subject to all billing cycle efforts. If the guarantor does not submit a financial assistance application and is approved for presumptive financial assistance, the presumptive financial assistance will only apply to the guarantor's current balance and no previous or future payments made will be refunded.

Responsible Department: Patient Financial Services

Related Policies: Departmental Uninsured Discount Policy, Financial Assistance Policy