

Policy Title: Froedtert ThedaCare Health South Region Billing and Collection Policy

Policy Number: 1017

Origination Date: 02/14/2012

I. Purpose Statement

- A. To establish general guidelines for the expected receipt of payment for emergency medical care or other necessary medical care provided by Froedtert ThedaCare Health South Region. This Policy, however, does not apply to Froedtert Health Pharmacy Solutions, LLC, or Wisconsin Diagnostic Laboratories, LLC's outreach business. This Policy also establishes certain requirements to meet prior to taking certain collection actions against individuals who may be eligible for financial assistance ("Financial Assistance") under the PFS Financial Assistance Policy.

II. Policy

- A. The South Region submits claims to Medicare, Medicaid and/or other third-party payors. Any portions not covered by insurance are the responsibility of the patient. (For purposes of this Policy, references to "patient" includes, where applicable, the individual acting as the guarantor of payment of the patient's invoice for medical care.) The ultimate financial responsibility for payment lies with the patient.
- B. No individual is refused treatment for emergency medical care or other medically necessary care due to demonstrated financial hardship or inability to pay.

III. Procedure

- A. A patient requiring emergency medical services or other medically necessary care is given appropriate treatment immediately. Promptly after services are provided, the patient, a family member, or other responsible party is required to provide all information necessary to properly identify the patient and to make arrangements for payment for all medical services.
- B. Individuals requiring non-emergency medical services or other non-medically necessary care, and individuals seeking elective services are required to make financial arrangements for the payment of medical care prior to receiving the services.
 - 1. Each patient who claims financial hardship or the inability to pay is required to complete an application requesting consideration for Financial Assistance in accordance with the PFS Financial Assistance Policy. Failure to comply with the Financial Assistance application requirements may result in services, other than emergency medical services or other medically necessary care, being denied, or if services are rendered, payment for such services may be pursued in accordance with

- standard policies and procedures, including this Policy, and in compliance with applicable federal and state laws.
2. Each patient with insurance or other form of third-party coverage is required to provide all information requested to properly identify the patient/guarantor and bill the third-party payor. Benefit coverage is verified, and precertification is completed. If an assignment of benefits is received, all accepted insurance is billed by the entity providing the service. Deductibles and coinsurance amounts not paid by insurance are expected to be paid by the patient/guarantor(s). Patients may be asked to pay amounts towards deductible, co-insurance, or co-pays at the point of scheduling, check in or after services are rendered with receipt of the first invoice, unless alternative acceptable payment arrangements are established.
 3. Each patient seeking non-emergency medical care or other non-medically necessary care which is not covered by insurance or other third-party payors is expected to pay in advance estimated charges less any applicable discounts applied. If the actual charges are greater than the collected amount, the patient is sent an invoice for the balance. If the actual charges are less than the collected amount, the patient is refunded the excess amount.
- C. Payments for services provided to patients are the responsibility of the patient/guarantor including those which appear to be covered services by the patient's third-party payor.
1. Reasonable efforts are made to educate the patient concerning the financial responsibility they are accepting prior to the provision of services. An explanation of billing and payment procedures may occur during scheduling or check in. Brochures that explain the billing and collection procedures are provided to the patient/guarantor before admission or registration for outpatient surgery, whenever possible. The same information is available on Froedtert.com.
 2. Forms of acceptable payment include insurance, cash, check, credit card. These forms of payment are explained to the patient before registration, when reasonably possible. Prompt payment is expected unless there are extenuating circumstances. Patients are expected to pay the patient liability amount in full within 120 days of receiving the first billing statement unless a monthly payment plan is agreed upon. The Organization may agree to monthly payment arrangements depending upon the patient's account balance. Payments will not be extended beyond 36 months unless there are extenuating circumstances. Payment arrangements beyond 36 months must be approved in advance by the Patient Financial Services Manager or designee. Accounts with unpaid balances that are not in an agreed payment plan are referred to a collection agency no less than 120 days after the first post-discharge billing statement and in accordance with this Policy. Patients are sent a minimum of three invoices during the 120 days period and contacted regarding the unpaid balances a minimum of three times unless the patient specifically requested not to be called or sent invoices, or the address or phone number on file is incorrect.

3. The following patients are referred to a Financial Counselor to be screened for potentially available government programs:
 - a. Patients scheduled to receive medical care who are without health insurance.
 - b. Patients scheduled to receive elective services such as cosmetic surgery or other services which are not covered by the patient's health insurance benefits.
 - c. Patients without health insurance who receive emergency medical care or other medically necessary care, or who are admitted to a South Region hospital facility.

In the event that a patient is unable to pay for services, the Organization will assist the patient in applying for any available source of financial assistance. Examples include Wisconsin Medicaid Program (Title XIX), Wisconsin AIDS/HIV Laboratory Reimbursement Program, Crime Victim Compensation Fund, and enrollment in an insurance plan available through the federal Health Insurance Marketplace. Refusal of the patient to cooperate in this effort may result in denial of services except for emergency medical care or other medically necessary care. Financial Assistance may be offered according to the PFS Financial Assistance Policy.

Billing and Collection Procedures:

- D. For those individuals who qualify or may qualify for financial assistance under the PFS Financial Assistance Policy, the Organization will not engage in any Extraordinary Collection Action against the individual to collect payment for medical care before the Organization has made reasonable efforts to determine whether an individual is eligible for such financial assistance. This also applies with respect to any other individual who may be responsible for the payment of the patient's medical bill for such care.
- E. Each of the following actions which may be taken by the Organization related to a billing statement for medical care covered under the PFS Financial Assistance Policy, is considered an Extraordinary Collection Action (ECA):
 1. Selling an individual's debt to another party for purposes of collection;
 2. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus;
 3. Deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the PFS Financial Assistance Policy;
 4. Actions that require a legal or judicial process (except for the placement of certain liens which a hospital is entitled to assert under state law); and
 5. Garnishing an individual's wages.
- F. In an effort to determine whether an individual is eligible for financial assistance, at least 30 days prior to initiating an ECA to obtain payment for care (and subject to the 120-day notification period provided for in statement G below), the Organization will:
 1. Notify the individual/guarantor about the PFS Financial Assistance Policy, identify the ECA(s) that Froedtert Health intends to take to obtain payment, and states the

- deadline after which the ECA(s) may be taken (which cannot be less than 30 days following the date that the notice is provided to the individual/guarantor);
2. Provide the individual/guarantor with a plain language summary of the PFS Financial Assistance Policy with the written notice described in statement F.1. above; and
 3. Make reasonable effort to orally notify the individual/guarantor about the PFS Financial Assistance Policy and about how they may apply for such financial assistance. This may be done by offering the patient a billing brochure which describes Financial Assistance at check in, or by Financial Counselors offering uninsured patients Financial Assistance information, or during conversations with the patient during the billing process.
- G. The Organization will not initiate any ECA for at least 120 days from the date the Organization delivers the first post-discharge billing statement for care.
- H. If an individual submits an incomplete Financial Assistance application during the Application Period (as defined in statement K below), the Organization will notify the individual about how to complete the application. The individual is given a reasonable opportunity to complete and submit the application. During this time, the Organization will suspend any ECA it has initiated with respect to the individual and it will provide the individual with a written notice that describes the additional information that must be submitted and includes the contact information at the Organization at which the individual can obtain information about the PFS Financial Assistance Policy, and the department within the Organization which can provide assistance with the Financial Assistance application.
1. ECAs are suspended until the Organization has either determined whether an individual is eligible for Financial Assistance based upon a complete Financial Assistance, or the individual has failed to respond to requests for additional information within a reasonable period of time given by the Organization to respond to such requests.
 2. If an individual subsequently submits a complete application during the Application Period (or, if later, such other reasonable timeframe allowed by the Organization), then the Organization will take the following actions set forth in statements I.1. – I.5. below.
- I. If an individual subsequently submits a complete application during the Application Period (or, if later, such other reasonable timeframe allowed by the Organization), then the Organization will take the following actions in a timely manner:
1. Suspend any ECAs that have been initiated with respect to the individual/guarantor;
 2. Determine whether the individual is eligible for Financial Assistance and notify the individual of the determination and the basis for such determination;
 3. If the individual is eligible for Financial Assistance other than free care, then provide the individual with a billing statement that specifies the amount the individual owes for the medical care, how that amount was determined and states how the

- individual may obtain information regarding the amounts generally billed (AGB) for such medical care;
4. Refund any excess amount which the individual has paid over that amount for which the individual is determined to be responsible for considering the Financial Assistance eligibility (unless such excess is less than \$5); and
 5. Take all reasonable measures to reverse any ECAs taken against the individual.
- J. Upon submission of a complete Financial Assistance application during the Application Period, the Organization will:
1. Make a determination as to whether the individual qualifies for financial assistance within a reasonable timeframe; and
 2. Take the actions set forth in statements I.1 – I.5 above.
- K. In those circumstances where the Organization reasonably believes that the individual may qualify for Medicaid, the Organization may postpone determining whether an individual is eligible for Financial Assistance under the PFS Financial Assistance Policy until such time that a Medicaid application has been submitted and a determination as to such individual's Medicaid eligibility has been made.
- L. If the Organization sells or refers a patient's debt to a third party, the Organization will take appropriate measures to safeguard against such third party taking ECAs against the patient to obtain payment for the medical care until the Organization has made reasonable efforts to determine if the patient is eligible for Financial Assistance in accordance with process outlined in this Policy. Such safeguards will include entering into a written agreement with the third party designed to facilitate the Organization's compliance with this Policy and applicable federal statutes and regulations.
- M. For purposes of this Policy, the "Application Period" is the period during which an individual must submit a Financial Assistance application pursuant to the PFS Financial Assistance Policy. This period begins on the date on which emergency medical care or other medically necessary care is provided and ends on the 240th day after the first post-discharge billing statement for such care is provided, except as otherwise provided in this Policy.

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