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Policy: Patient Accounting Services Billing and Collections Policy  
Approved By: Executive Sponsor  
Last Revised: 6/23/2020

# Patient Accounting Services, Patient Billing and Collections Policy

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## Policy Type

- |   |   |
|---|---|
| <input type="checkbox"/> Entity Governance Policy   | <input type="checkbox"/> System Governance Policy   |
| <input type="checkbox"/> Entity Policy              | <input checked="" type="checkbox"/> System Policy   |
| <input type="checkbox"/> Entity Departmental Policy | <input type="checkbox"/> System Departmental Policy |
|   | <input type="checkbox"/> Home Office Policy         |

## Policy Scope

- |  |   |
|--|---|
| <input type="checkbox"/> Summa Health (Corporate)              | <input checked="" type="checkbox"/> Summa Health System (Hospitals)             |
| <input type="checkbox"/> Summa Health Network                  | <input type="checkbox"/> New Health Collaborative                               |
| <input checked="" type="checkbox"/> Summa Health Medical Group |   |
| <input type="checkbox"/> Summacare                             | <input checked="" type="checkbox"/> Department: <u>Patient Account Services</u> |



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**1.0 Purpose:**

Summa Health System (SHS) is committed to providing education to patients and guarantors as it relates to billing and collections of payment for services rendered. Payment on accounts will be pursued consistently, regardless of race, age, gender, ethnic background, national origin, citizenship, primary language, religion, education, employment or student status, disposition, relationship, insurance coverage, community standing, or any other discriminatory differentiating factor. To that end, Summa Health System will not engage in any extraordinary collection actions (or “ECAs” as defined herein) against an individual to obtain payment for care before reasonable efforts have been made to determine whether the individual is eligible for assistance for the care under its Financial Assistance Policy (FAP) .

Every guarantor will be given reasonable time and communication to be aware of and understand their financial responsibility. The guarantor will be held financially responsible for services actually provided and adequately documented. Summa Health System representatives and/or its designee will widely publicize its FAP. Understanding each patient’s insurance coverage is the responsibility of the policyholder. Any residual patient liability secondary to insurance coverage is defined by the guarantor's insurance coverage and benefit design.

Summa Health System relies on the explanation of benefits and other information from the guarantor and the insurance carrier for eligibility, adjudication of the claim, and patient out of pocket responsibility determinations.

**2.0 Scope:**

The Guarantor Billing and Collections Policy applies to the Summa Health System (Hospitals).

**3.0 Definitions:**

Summa Health System (SHS) – is a non-profit integrated healthcare delivery system in Northeast Ohio, United States. Summa Health System Corporate Service Center is located at: 1077 Gorge Blvd, Akron, Ohio 44310.



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Extraordinary Collection Actions (ECAs) – Include 1) selling an individual’s debt to another party 2) reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus 3) deferring or denying, or requiring payment before providing medically necessary care because of nonpayment of previous bills 4) actions that require a legal or judicial process such as commencing a civil action against an individual and placing a lien on an individual’s property (although exceptions include filing a proof of claim in bankruptcy and hospital liens on personal injury judgments/settlements.)

Financial Assistance Policy (FAP) - is a program that is fully funded by Summa Health System. It covers patients without health insurance and those with only partial insurance coverage (i.e. the uninsured and underinsured) who meet the income and other eligibility criteria described herein.

#### 4.0 Policy

A statement of hospital services is sent to the patient/guarantor in incremental billing cycles. In cases when the patient has no insurance coverage, that is a self-pay patient, the statement is sent after services are rendered. In most cases when patients have coverage through an insurance carrier, the statements are sent after the services have been rendered, claim is submitted, and claim has been adjudicated by the insurance carrier. There are some cases, for example, when there is a stop in the adjudication of a claim due to the patient needing to provide additional information, where a statement will be sent to the patient and/or guarantor prior to claim processing.

Summa Health System representatives and/or their designees may attempt to contact the patient/guarantor (including but not limited to contact via telephone/cell phone, mail, or email) during the statement billing cycle in order to pursue collections. Collection efforts are documented on the patient's account.

#### Statement Cycle:

The statement and bad debt write off cycle will be measured from the first statement sent to the patient (date sent) and continue at approximately 30 day intervals until 4 statements over an approximately 120 day time period have been sent. Outbound calls may also be made during this period.

- Examples of when 4 statements might not be sent include mail returned as undeliverable or patient is deceased.

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**Extraordinary Collection Actions (ECAs):**

It is the policy of Summa Health System not to engage in ECAs (as noted in ‘Definitions’) against an individual to obtain payment for care before making reasonable efforts to determine whether the individual is eligible for assistance under its FAP.

Summa Health System may pursue all available means in the collection of delinquent accounts including outsourcing accounts to a collection agency and those actions requiring a legal or judicial process. However, legal action will NOT include bank garnishment, repossession of assets and foreclosures. Summa Health System must be notified of and approve of any legal action being taken in the collection of delinquent accounts by any vendors working on behalf of Summa Health System.

**Efforts to Determine FA Eligibility:**

- Summa Health System will allow patients to submit complete FA applications during a minimum 240-day Application Period (as described herein).
- Summa Health System will not engage in ECAs against the patient or guarantor without making reasonable efforts to determine the patient's eligibility under the FAP. Specifically:
  - o Summa Health System will notify individuals about the FAP as described herein before initiating any ECAs to obtain payment for the care and refrain from initiating such ECAs for at least 120 days from the first post-discharge billing statement for the care.
- If Summa Health System intends to pursue ECAs, the following will occur before initiating one or more ECAs:
- Summa Health System will notify the patient in writing that financial assistance is available for eligible individuals, identifies the ECAs the facility (or other authorized party) intends to initiate to obtain payment for the care, and states a deadline after which such ECAs may be initiated that is no earlier than 30 days after the date that the written notice is provided; The above notice will include a plain language summary of the FAP; Summa Health System will make a reasonable effort to orally notify the patient about the FAP and how the individual may obtain assistance with the application process.

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- If Summa Health System aggregates an individual's outstanding bills for multiple episodes of care before initiating one or more ECAs to obtain payment for those bills, it will refrain from initiating the ECAs until 120 days after it provided the first post-discharge billing statement for the most recent episode of care included in the aggregation.
- If Summa Health System defers or denies, or requires a payment before providing, medically necessary care to an individual with one or more outstanding bills for previously provided care, Summa Health System will provide the individual with a FA application form and a written notice indicating that FA is available for the eligible individuals and stating the deadline, if any, after which Summa Health System will no longer accept and process a FA application submitted or, if applicable, completed by the individual for the previously-provided care. The deadline will be no earlier than the later of 30 days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement for the previously-provided care was provided. Summa Health System will also provide the individual with a plain language summary of the FAP with the written notice, and make a reasonable effort to orally notify the individual about Summa Health System's FAP and about how the individual may obtain assistance with the FA application process. If a FA application is timely received by Summa Health System, it will process the application on an expedited basis.

**Processing FA Applications:**

If an individual submits an *incomplete* FA application during the application period, Summa Health System will:

- Provide the individual with a written notice that describes the additional information and/or documentation required under the FAP or FA application form that must be submitted to complete the application and that includes the Summa Health System contact information set forth on Page 8.

If an individual submits a *complete* FA application during the application period, Summa Health System will:

- Make an eligibility determination as to whether the individual is FA-eligible for the care and notify the individual in writing of the eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination.

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If the individual is determined to be FA-eligible for their care, Summa Health System will:

- If the individual is determined to be eligible for assistance other than free care, provide the individual with a billing statement that indicates the amount the individual owes for the care as an FA-eligible individual and how that amount was determined and states, or describes how the individual can get information regarding, the Average Generally Billed (AGB) for the care.
- Refund to the individual any amount he or she paid for the care (whether to Summa Health System or any other party to whom Summa Health System has referred the individual's debt for the care) that exceeds the amount he or she is determined to be personally responsible for paying as an FA-eligible individual, unless such excess amount is less than \$5 (or such other amount published in the Internal Revenue Bulletin).

When no FA application is submitted, unless and until Summa Health System receives a FA application during the Application Period, Summa Health System may initiate ECAs to obtain payment for the care once it has notified the individual about the FAP as described herein.

## 5.0 References

Summa Health System offers various options for uninsured and underinsured patients who do not qualify for FA under its FAP. For further information, please see the following Summa Health System policies, or contact Summa Health System as indicated on Page 8 of this policy:

- Summa Health System Adherence to Internal Revenue Code § 501(r) Policy;  
Summa Health System Financial Assistance Policy
- Summa Health System Financial Aid Catastrophic Policy

### Miscellaneous Provisions:

**Anti-Abuse Rule** – Summa Health System will not base its determination that an individual is not FA-eligible on information that Summa Health System has reason to believe is unreliable or incorrect or on information obtained from the individual under duress or through the use of coercive practices.



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**Determining Medicaid Eligibility** – Summa Health System will not fail to have made reasonable efforts to determine whether an individual is FA-eligible for care if, upon receiving a complete FA application from an individual who Summa Health System believes may qualify for Medicaid, Summa Health System may postpone determining whether the individual is FA-eligible for the care until after the individual's Medicaid application has been completed and submitted and a determined as to the individual's Medicaid eligibility has been made.

**No Waiver of FA Application** – Obtaining a signed waiver from an individual, such as a signed statement that the individual does not wish to apply for assistance under the FAP or receive the notifications described herein, will not itself constitute a determination that the individual is not FA-eligible.

**Final Authority for Determining FA Eligibility** – Final authority for determining that Summa Health System has made reasonable efforts to determine whether an individual is FA-eligible and may therefore engage in ECAs against the individual rests with the Summa Health System Patient Financial Services Department.

**Agreements with Other Parties** – If Summa Health System sells or refers an individual's debt related to care to another party, Summa Health System will enter into a legally binding written agreement with the party that is reasonably designed to ensure that no ECAs are taken to obtain payment for the care until reasonable efforts have been made to determine whether the individual is FA-eligible for the care.

**Providing Documents Electronically** - Summa Health System may provide any written notice or communication described in this policy electronically (for example, by email) to any individual who indicates he or she prefers to receive the written notice or communication electronically.



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**Financial Counselors**

Financial counselors are available to answer your questions about payment arrangements, insurance coverage, Medicare and other financial inquiries.

For more information about financial counseling, please call:

- Summa Health System – Akron Campus (330) 375-6685
- Summa Health System – Barberton Campus (330) 615-3236

**Patient Customer Services**

Contact Summa Patient Customer Service at 234.312.5700 or 800.543.7750 (in Ohio).  
Representatives are available Monday through Thursday from 8:00 am to 5:00pm and Fridays 8:00am to 4:30pm.