



Highpoint Health - Billing and Collection Policy

Policy

After our patients have received services, it is the policy of Highpoint Health to bill patients and applicable payers accurately and in a timely manner. During this billing and collections process, staff will provide quality customer service and timely follow-up, and all outstanding accounts will be handled in accordance with section 501(r) of the Patient Protection and Affordable Care Act, and the Treasury Regulations issued thereunder, and other applicable laws and regulations.

Purpose

It is the goal of this policy to provide clear and consistent guidelines for conducting billing and collections functions in a manner that promotes compliance, patient satisfaction, and efficiency. Through the use of billing statements, written correspondence, and phone calls, Highpoint Health will make diligent efforts to inform patients of their financial responsibilities and available financial assistance options, as well as follow up with patients regarding outstanding accounts. Additionally, this policy requires Highpoint Health to make reasonable efforts to determine a patient's eligibility for financial assistance under Highpoint Health's financial assistance policy before engaging in extraordinary collection actions to obtain payment.

This policy applies to the following Highpoint Health hospitals:

- Highpoint Health -Dearborn

Definitions

AGB: Amounts generally billed for emergency or other medically necessary care to individuals who have insurance coverage.

Application Period: The period during which Highpoint Health must accept and process an application for financial assistance under its financial assistance policy submitted by an individual in order to have made reasonable efforts to determine whether the individual is eligible for financial assistance under the policy. The Application Period begins on the date the care is provided and ends on the latter of the 240th day after the date that the first post-discharge billing statement for the care is provided or at least 30 days after Highpoint Health (or Highpoint Health’s authorized business partners) provides the individual with a written notice that sets a deadline after which ECAs may be initiated.

Extraordinary Collection Actions (ECAs): A list of collection activities, as defined by the IRS and Treasury, that healthcare organizations may only take against an individual to obtain payment for care *after* reasonable efforts have been made to determine whether the individual is eligible for financial assistance. These actions are further defined in Section II of this policy and include actions such as legal/judicial actions such as garnishing wages.

Financial Assistance Policy (FAP): A separate policy that describes Highpoint Health’s financial assistance program—including the criteria patients must meet in order to be eligible for financial assistance as well as the process by which individuals may apply for financial assistance.

Reasonable Efforts: A certain set of actions a healthcare organization must take to determine whether an individual is eligible for financial assistance under Highpoint Health’s financial assistance policy. In general, reasonable efforts may include making presumptive determinations of eligibility for full or partial assistance as well as providing individuals with written and oral notifications about the FAP and application processes.

Procedures

I. Billing Practices

A. Insurance Billing

1. For all insured patients, Highpoint Health will bill applicable third-party payers (as based on information provided by or verified by the patient) in a timely manner.
2. If a claim is denied (or is not processed) by a payer due to an error on our behalf, Highpoint Health will not bill the patient for any amount in excess of what the patient would have owed had the payer paid the claim.
3. If a claim is denied (or is not processed) by a payer due to factors outside of our organization’s control, staff will follow up with the payer and patient as appropriate to facilitate resolution of the claim. If resolution does not occur after prudent follow-up efforts, Highpoint Health may bill the patient or take other actions consistent with current regulations and industry standards.

B. Patient Billing

1. All uninsured patients will be billed directly and timely, and they will receive a statement as part of the organization's normal billing process.
2. For insured patients, after claims have been processed by third-party payers, Highpoint Health will bill patients in a timely fashion for their respective liability amounts as determined by their insurance benefits.
3. All patients may request an itemized statement for their accounts at any time.
4. If a patient disputes his or her account and requests documentation regarding the bill, staff members will provide the requested documentation in writing within 10 days (if possible) and will hold the account for at least 30 days before referring the account for collection.
5. Highpoint Health may approve payment plan arrangements for patients who indicate they may have difficulty paying their balance in a single installment.
 - a. Patient Financial Services supervisors and directors have the authority to make exceptions to this policy on a case-by-case basis for special circumstances.
 - b. Highpoint Health is not required to accept patient-initiated payment arrangements and may refer accounts to a collection agency as outlined below if the patient is unwilling to make acceptable payment arrangements or has defaulted on an established payment plan.

II. Collection Practices

A. Extraordinary Collection Actions (ECAs) - In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Billing and Collection Policy, Highpoint Health may engage in collection activities—including extraordinary collection actions (ECAs)—to collect outstanding patient balances.

1. General collection activities may include follow-up calls on statements.
2. Patient balances may be referred to a third party for collection at the discretion of Highpoint Health. Highpoint Health will maintain ownership of any debt referred to debt collection agencies, and patient accounts will be referred for collection only with the following caveats:
 - a. There is a reasonable basis to believe the patient owes the debt.
 - b. All third-party payers have been properly billed, and the remaining debt is the financial responsibility of the patient. Highpoint Health shall not bill a patient for any amount that an insurance company is obligated to pay.
 - c. Highpoint Health will not refer accounts for collection while a claim on the account is still pending payer payment. However, Highpoint Health may classify certain claims as "denied" if such claims are stuck in "pending" mode for an unreasonable length of time despite efforts to facilitate resolution.
 - d. Highpoint Health will not refer accounts for collection where the claim was denied due to a Highpoint Health error. However, Highpoint Health may still refer the patient liability portion of such claims for collection if unpaid.

- e. Highpoint Health will not refer accounts for collection where the patient has initially applied for financial assistance or other Highpoint Health-sponsored program and Highpoint Health has not yet notified the patient of its determination (provided the patient has complied with the timeline and information requests delineated during the application process).

B. Notification Prior to ECA

1. Before engaging in ECAs to obtain payment for care, Highpoint Health must make certain reasonable efforts to determine whether an individual is eligible for financial assistance under our financial assistance policy:
 - a. Highpoint Health will notify the individual about the FAP before initiating any ECAs to obtain payment for the care, and refrain from initiating ECAs for at least 120 days from the first post-discharge billing statement for the care.
 - b. However, at least 30 days before initiating ECAs to obtain payment, Highpoint Health (or its authorized business partners) shall do the following:
 - i. Provide the individual with a written notice that indicates the availability of financial assistance, lists potential ECAs that may be taken to obtain payment, and gives a deadline after which ECAs may be initiated (no sooner than 120 days after the first post-discharge billing statement and 30 days after the written notice).
 - ii. Provide a plain-language summary of the FAP along with the notice described above.
 - iii. Attempt to notify the individual orally about the FAP and how he or she may get assistance with the application process.
 - c. If Highpoint Health 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 ECAs until 120 days after it provided the first post-discharge billing statement for the most recent episode of care included in the aggregation.
2. After making reasonable efforts to determine financial assistance eligibility as outlined above, Highpoint Health (or its authorized business partners) may take bank and wage garnishment action to obtain payment for care.
3. Highpoint Health's Self Pay Department is ultimately responsible for determining whether Highpoint Health and its business partners have made reasonable efforts to determine whether an individual is eligible for financial assistance. This body also has final authority for deciding whether the organization may proceed with any of the ECAs outlined in this policy.

III. Financial Assistance

A. All billed patients will have the opportunity to contact Highpoint Health regarding financial assistance for their accounts, payment plan options, and other applicable programs.

1. Highpoint Health's Financial Assistance Policy (FAP), FAP application, and plain language summary of the FAP, are available in **English**, free of charge, in the following ways:
 - a. In person at 600 Wilson Creek Rd Lawrenceburg, IN 47025 at the Cashiers Office.
 - b. By calling the financial counseling department at 812-537-8404 or mailing a request to 600 Wilson Creek Rd Lawrenceburg, IN 47025 Attn: Financial Assistance Dept.
 - c. Online at <https://www.myhph.org/patients-visitors/pay-my-bill/> and choose the link found in the Financial Assistance section.
 - d. Notification on the back of the billing statement.
2. Individuals with questions regarding Highpoint Health's Financial Assistance Policy may contact the financial counseling office by phone at 812-537-8404 or in person at Highpoint Health, 600 Wilson Creek Rd Lawrenceburg, IN 47025
3. Highpoint Health Financial Assistance Policy is for facility services only. A listing of provider groups not associated with the hospitals financial assistance programs can be found on our website at <https://www.myhph.org/patients-visitors/pay-my-bill/>, provided by calling customer service, or obtaining a copy at the address in III.A.1 above. This list is updated quarterly.

IV. Processing FAP Applications; Time Frames

A. Incomplete FAP Applications

1. If an individual submits an *incomplete* FAP application during the Application Period, Highpoint Health will:
 - a. Suspend any ECAs to obtain payment for the care; and
 - b. Provide the individual with a written notice that describes the additional information and/or documentation required under the FAP or FAP application form that must be submitted to complete the application. This notice will include the Highpoint Health contact information set forth on Page 4.

B. Complete FAP Applications

1. If an individual submits a *complete* FAP application during the Application Period, Highpoint Health will:
 - a. Suspend any ECA previously initiated to obtain payment for the care;
 - b. Make an eligibility determination as to whether the individual is FAP-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.

- c. If the individual is determined to be FAP-eligible for the care, Highpoint Health will:
 - Provide the individual with a written notification that indicates the amount the individual owes for the care under the FAP, how that amount was determined and how the individual can get information regarding the AGB for the care.
 - Refund to the individual any amount he or she paid for the care that exceeds the amount he or she is determined to be personally responsible for paying under the FAP, unless such excess amount is less than \$5 (or such other amount published in the Internal Revenue Bulletin).
 - Take all reasonably available measures to reverse any ECA (with the exception of a sale of debt) taken against the individual to obtain payment for the care.

C. Failure to Submit a FAP Application

When no FAP application is submitted during the Application Period, Highpoint Health may initiate ECAs to obtain payment for the care once it has notified the individual about the FAP as described in Section II.B.1 above.

V. Customer Service

A. During the billing and collection process, Highpoint Health will provide quality customer service by implementing the following guidelines:

1. Highpoint Health will enforce a zero tolerance standard for abusive, harassing, offensive, deceptive, or misleading language or conduct by its employees.
2. Highpoint Health will maintain a streamlined process for patient questions and/or disputes, which includes a toll-free phone number patients may call and a prominent business office address to which they may write. This information will remain listed on all patient bills and collections statements sent.
3. After receiving a communication from a patient (by phone or in writing), Highpoint Health staff will return phone calls to patients as promptly as possible (but no more than one business day after the call was received) and will respond to written correspondence within 10 days.

VI. Miscellaneous

- A. Anti-Abuse Rule** – Highpoint Health will not base its determination that an individual is not FAP-eligible on information that Highpoint Health has reason to believe is unreliable or incorrect or on information obtained from the individual under duress or through the use of coercive practices.
- B. Determining Medicaid Eligibility** – Highpoint Health will not fail to have made reasonable efforts to determine whether an individual is FAP-eligible for care if, upon receiving a complete FAP application from an individual who Highpoint Health believes may qualify for Medicaid, Highpoint Health postpones determining whether the individual is FAP-eligible for the care until after the individual's Medicaid application has been submitted and a determination as to the individual's Medicaid eligibility has been made.

C. Agreements with Other Parties – If Highpoint Health sells or refers an individual’s debt related to care to another party, it will first enter into (and, to the extent applicable, enforce) 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 FAP-eligible for the care.