



Title	Collections, NGMC
Primary Reviewer	Director, System Patient Receivables
Reviewer(s)	Director, Patient Access and Scheduling; Executive Director, Hospital Revenue Cycle Operations, Chief Revenue Cycle Officer, VP of Managed Care and Integration Strategies; Chief Compliance Officer; Policy Steering Committee (PSC)

1. Select ALL ENTITIES that the document applies by placing an 'x' to the left of the entity.								
X	NGMC Gainesville-Braselton	X	NGMC Barrow	X	NGMC Lumpkin	X	NGMC Habersham	NGHS Ambulatory Surgery Centers (ASC)
	NGMC Gainesville Campus Only		NGMC Braselton Campus Only		Northeast Georgia Physicians Group		Georgia Heart Institute	NGHS Foundation
	NGHS Auxiliary		Northeast Georgia Health Partners		Hospice of NGMC		New Horizons -- LTC	HealtheConnection
	NGHS Corporate Department		NGHS Unified Medical Staff		Longstreet at NGHS		Other: (specify)	
2. If Department Specific Only , list Department Name and Campus, if applicable to only one campus.								
3. Select ALL BOARDS that the document applies by placing an 'x' to the left of the entity.								
	NGHS Board		NGMC Gainesville-Braselton Board		NGMC Barrow Board		NGMC Lumpkin Board	NGMC Habersham Board
	Georgia Heart Institute Board		Northeast Georgia Health Partners Network Board (CIN)		NGHS Foundation Board		NGPG Board	Braselton ASC Board

I. Purpose

Provides guidelines to ensure consistent processing for collections. It is the policy of Northeast Georgia Medical Center (NGMC) to provide patients/guarantors with account resolution options, for which they qualify (including Financial Assistance), prior to engaging in extraordinary collection actions. This policy establishes billing time limits and actions that may be taken in the event of nonpayment for medical care provided by NGMC, including collection actions, reporting to credit bureaus, etc. NGMC complies with all applicable federal, state and local laws.

II. Definitions

Account Resolution

is defined as patient liability has been resolved when either of the following has occurred: 1) payment in full; 2) discounted payment in full (financial assistance discounts, etc.); 3) payment plan established and in good standing; or 4) financial assistance approved for 100% write-off or percentage discount with payment in full or payment plan established and in good standing.

Amount Generally Billed (AGB)

is defined as the maximum amount allowed to charge a financial assistance eligible patient.

Bad Debt

is defined as unresolved accounts aged to 120 days, post discharge.

Catastrophic Adjustment

is defined as an account adjustment that may be provided where patient liability is \$10,000, or more.

Extraordinary Collection

Actions (ECAs)

are defined as actions that require a legal or judicial process or involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, “credit agencies”).

Financial Assistance

is defined as full or partial patient balance adjustment due to patient qualifying through eligibility criteria, as defined in the Financial Assistance policy.

Service Recovery

Attempts to recover the customer experience and maintain a good relationship when inadvertent delays and/or multiple billing errors have caused the patient to have an unfavorable experience with Customer Service.

III. Policy

Pre-Service and Point of Service Account Resolution

- 1) NGMC will make reasonable efforts to provide patients/guarantors with an estimate of patient financial liability prior to services rendered.
- 2) The patient/guarantor will be asked to make payment in full or set up payment plan prior to service for scheduled cases or at registration/check-in for walk-ins/add-ons.
- 3) If the patient/guarantor feels they may qualify for financial assistance, prior to being required to make an upfront payment, the patient/guarantor will be referred to the Financial Counseling Department for eligibility processing.
- 4) If the patient/guarantor is unable to pay the estimated amount in full, set up a payment plan or is referred for financial assistance processing, the service may be postponed, depending on medical necessity criteria.
- 5) Patients will be offered a plain language summary of the Financial Assistance policy upon registration.
- 6) Patients presenting for emergency care or in active labor will be provided a medical screening and stabilization, if needed, prior to being asked to make payment of estimated patient liability, in compliance with The Emergency Medical Treatment and Labor Act (EMTALA).

Discounts

- 1) Self-pay Discount - All self-pay (true or elected) patients receive a discount equal to 46% of total charges. Insured patients can elect not to have their insurance filed to take advantage of the self-pay discount. To do so, patients must complete the “elected self-pay agreement” form prior to or at time of service.
- 2) Prompt Pay Discount – Self pay (true or elected) patients are eligible to receive a 15% discount, if payment in full is made prior to, at time of service, or within 30 days after the first statement is sent to the patient.
- 3) Case Rates – Some elective procedures are deemed non-covered by insurance plans and offered at our lowest discounted case rates. These procedures do not qualify for additional discounts. The list of elective procedures and applicable case rates are subject to change and are managed by the-Patient Access Service Center.
- 4) Catastrophic Adjustment
 - a) Patients with account balances of \$10,000 or more can be considered for a catastrophic discount. Patients owning property cumulatively valued above the average fair market value for the patient’s zip code will not qualify for catastrophic adjustment. If the patient qualifies, the account balance will be adjusted, reducing patient liability to an amount equal to 25% of their estimated annual disposable net family income.

- 5) Administrative Adjustment
 - a) Administrative adjustments are approved via discretionary means. An example of an administrative adjustment is a service recovery discount.
 - b) Administrative Adjustment Approval Levels
 - T1 - \$300 - \$4,999.99 Approved by Revenue Cycle Supervisor
 - T2 - \$5,000 – \$9,999.99 Approved by Revenue Cycle Manager
 - T3 - \$10,000 - \$14,999.99 Approved by Revenue Cycle Director
 - T4 - \$15,000 - \$19,999.99 Approved by Revenue Cycle Executive Director
 - T5 - >\$20,000 Approved by VP Revenue Cycle

Payment Plans

- 1) Payment plans up to 60 months, based on balance, are accepted and handled by Patient Contact Center staff.
- 2) Payment plans exceeding 60 months may be approved by the System Patient Receivables Management Team.

Patient Billing / Contact After Service

- 1) Insured Patients: Once all insurances have adjudicated (paid or denied) their claims, the first post-discharge billing statement outlining remaining patient liability is sent to the patient/guarantor. If no response is received from the insurance company for seventy-five (75) days from claim submission date, the first post-discharge billing statement outlining the remaining patient liability is sent to the patient/guarantor.
 Uninsured Patients: Once the patient's account has final billed, the first post-discharge billing statement is sent to the patient/guarantor.
- 2) Account processing for patients who are approved for Financial Assistance will follow the Financial Assistance processing. See NGMC Financial Assistance policy.
- 3) For unresolved accounts, a billing statement is sent to the patient/guarantor every thirty (30) days for four (4) billing statements. Each billing statement provides contact information for our financial assistance department, including department telephone number and Website address where a copy of the NGMC Financial Assistance Policy, Plain Language Summary, and Application in English and Spanish may be downloaded. The dunning message on the billing statement progresses with each successive statement.
- 4) Accounts remaining unresolved that have aged one hundred twenty (120) days from date of first post-discharge billing statement are placed in Bad Debt status and are referred to the NGMC internal collection team. Up to two (2) collection letters are sent to the patient/guarantor. The collection letters conspicuously provide contact information for financial assistance information, including department telephone number and Website address where a copy of the NGMC Financial Assistance Policy, Plain Language Summary, and Application in English and Spanish may be downloaded.
- 5) A final delinquency letter is sent on day 151, identifying the ECAs that NGMC intends to initiate to obtain payment.
- 6) Unresolved accounts aged one hundred eighty (180) days from date of first post-discharge billing statement are placed with secondary collection agency (see Collections Agencies below). During the 180 days prior to placement, NGMC collection staff makes regular phone calls to patient/guarantor. The content of the phone conversation will include oral notification of NGMC's Financial Assistance policy and how the individual may obtain assistance with the application process.

- 7) Financial assistance applications will be accepted up to the latter of 240 days from the date of the first post-discharge billing statement or 30 days from written notification of intended extraordinary collection actions. See NGMC Financial Assistance Policy.
- 8) Episode-of-Care: For aggregated multiple episode patient accounts, for purposes of measuring the 120 day and 240 day timeframes, outlined above, the first post-discharge billing statement used for timing will be the first post-discharge billing statement with the most recent date and/or for the most recent episode of care.
- 9) In compliance with the Telephone Consumer Protection Act, prior express written consent will be obtained from the patient for all autodialed and/or pre-recorded calls/texts sent/made to cell phones.

Collection Agencies

Unresolved patient balance accounts will be referred to the applicable contracted outside, secondary collection agency at the age of one hundred eighty (180) days from date of first post-discharge billing statement. An additional 60 days are allowed for the patient to dispute or resolve their balance, either through payment or financial assistance approval, before the account is reported to the Credit Bureaus. Other ECAs may also ensue.

Deceased Patient Accounts

A claim will be filed against the estate. If uncollectable, the balance will be written off to Deceased Charity.

Patient/Guarantor Bankruptcy

If patient/guarantor has filed Chapter 7,11 or 13 the balance will be written off to Bad Debt Bankruptcy Adjustment.

Small Balance Write Off

Balances of \$4.99, or less, will be written off after one hundred twenty (120) days. Balances of \$9.99 or less will be written off after one hundred eighty (180) days.

Untimely Billing

Accounts not billed to patient/guarantor for 1 year will be adjusted off to Untimely.

Account Audit

Patient balance questions will be reviewed by the Nursing Audit team for appropriate charges. Patient is notified of audit results. Erroneous charges, if any, will be removed and the claim re-billed.

Medicaid Eligibility

Self-pay accounts (all inpatient accounts and outpatient accounts with balances of \$2000, or more) will be referred to the NGHS Medicaid and Disability team.

Disability Cases

Disability cases will be referred to the NGHS Medicaid and Disability team

Motor Vehicle Accident Cases

Motor Vehicle Accident (MVA) cases will be referred to contracted debt collection attorney(s).

IV. References (Required for Patient Care Policies only)

N/A

V. Related Documents

NGMC Financial Assistance Policy