PETERSON
REGIONAL MEDICAL CENTER
&
AMBULATORY SURGERY CENTER

# BUS - Collection Policy

**Reference # 4818**
**Version 3**

## STATEMENT OF POLICY:

Peterson Regional Medical Center (PRMC) is the frontline caregiver providing medically necessary care for all people regardless of ability to pay. PRMC offers this care for ***all*** patients that come to our facility 24 hours a day, seven days a week, and 365 days a year.

PRMC assists patients in obtaining financial assistance from public programs and other sources whenever appropriate. To remain viable as it fulfills its mission, PRMC must meet its fiduciary responsibility to appropriately bill and collect for medical services provided to patients. It is important to note that while the federal and state government uses different names for the policies that hospitals must follow to show how they are providing financial assistance to patients; the overall requirements are the same, as a result, this policy is designed to comply with both the state of Texas rules on "Credit and Collection Policies:' and the federal HealthCare Reform Law's "Financial Assistance Policy" requirements as recently clarified by the Internal Revenue Service in their February, 2015 instructions to Form 990.

PRMC does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual preference, age, or disability in its policies or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pre-treatment deposits, payment plans, deferred or rejected admissions, Low Income Patient status as determined by the Texas Office of Medicaid, determination that a patient is low-income, or in its billing and collection practices.

These credit and collection policies are developed to ensure compliance with applicable criteria required under (1) the Texas Fair Dept and Collection Practices Act, (2) the Centers for Medicare and Medicaid Services Medicare Bad Debt Requirements (42 CFR 413.89), and (3) The Medicare Provider Reimbursement Manual (Part 1, Chapter 3) and (4) the Internal Revenue Code Section 501® as required under the Section 9007(a) of the federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and as recently clarified in the February, 2013 IRS clarification to reporting such information in the hospital IRS 990 returns..

PRMC is an acute care facility, dedicated to providing quality health care. No individual will be denied emergent care due to an inability to pay. If an individual requires immediate or emergency care or a physician deems treatment necessary, that care will be provided whether the individual is able to pay or not.
PRMC is a community-oriented, not-for-profit acute care hospital governed by a local Board of Directors. Our mission reflects the views and ideals of, and is upheld by, our directors, incorporators, employees, physicians, and volunteers. PRMC serves those who live or work in Kerr county and surrounding areas in need of our services. We provide services without regard to sex, race, age, creed, or financial status and strive to meet the needs of our patients. PRMC is an acute care hospital that provides a broad range of high quality medical and surgical services on an inpatient and outpatient basis.

PRMC is dedicated to improving the health status of the community by enhancing preventive and primary care, and by providing health education. We are also committed to improving access to care and to providing special services for the underserved. The hospital works in partnership with other community agencies and providers to achieve these and other community improvement goals.
We also foster collaboration and cooperation with other organizations to enhance services, reduce costs or more effectively meet needs.

**Exclusions:**
This policy is for Peterson Regional Medical, Peterson Ambulatory Care Center and Peterson Community Care Center bills only. This policy does not include or govern any third party billing, including but not limited to, ER physician bills, Radiologist bills, Pathologist bills, Anesthesiologist bills, Hospitalist bills, Peterson Medical Associate bills, and/or Peterson Urgent Care Center bills. These billings mentioned above are not governed by Peterson Regional Medical Center's policies.

**Pursuant to the federal ACA changes as clarified by the IRS, PRMC makes available it's Credit and Collection policy by posting it on the hospital's website as well as making it available upon request.**

**Delivery of Health Care Services**

PRMC evaluates the delivery of health care services for all patients who present for services regardless of their ability to pay. However, non-emergent or non-urgent health care services (i.e., elective or primary care services) may be delayed or deferred based on the consultation with PRMC's financial staff and, if necessary and, the patient's primary care provider. PRMC may decline to provide a patient with non-emergent, non-urgent services in those cases when PRMC is unable to identify a payment source or eligibility in a financial assistance program. Such programs include Medicaid; Crippled Children's Program; Texas Rehabilitation; Commission for the Blind; Victims of Violent Crimes; CHIP; County Indigent Health Care Program, and others. Choices related to the delivery and access to care is often defined in either the insurance carrier's or the financial assistance policy.

The urgency of treatment associated with each patient's presenting clinical symptoms will be determined by a medical professional as determined by local standards of practice, national and state clinical standards of care, and PRMC medical staff policies and procedures. Further, PRMC follows the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requirements by conducting a medical screening examination to determine whether an emergency medical condition exists.

For those patients that are uninsured or underinsured, PRMC will work with patients to assist with finding a financial assistance program that may cover some or all of their unpaid hospital bill(s). For those patients with private insurance, PRMC must work with the patient and the insurer to determine what may be covered under the patient's insurance policy. In the event PRMC is not able to get this information from the insurer in a timely manner, it is the patient's obligation to know what services will be covered prior to seeking non-emergency level and non-urgent care services. Determination of treatment based on medical conditions is made according to the following definitions:

**Emergency and Urgent Care Services:**
Any patient who comes to PRMC will be evaluated as to the level of emergency level or urgent care services without regard to the patient's identification, insurance coverage, or ability to pay.

a. Emergency Level Services includes: i. Medically necessary services provided after the onset of 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 organ or part or, with respect to a pregnant woman, as further defined in section 1867(e) (1) (B) of the Social Security Act, 42 U.S.C. § 1295dd(e)(1)(B). A medical screening examination and any subsequent treatment for an existing emergency medical conditions or any other such service rendered to the extent required pursuant to the federal EMTALA (42 USC 1395(dd) qualifies as an Emergency Level Service.

b. Urgent Care Services include: i. Medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a *prudent layperson would believe that the absence of medical attention within 24 hours* could reasonably expect to result in: placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent Care Services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health, but prompt medical services are needed.

c. EMTALA Level Requirements: i. In accordance with federal requirements, EMTALA is triggered for anyone who comes to PRMC's property requesting examination or treatment of an emergency level service (emergency medical condition), or who enters the emergency department requesting examination or treatment for a medical condition. Most commonly, unscheduled persons present themselves at the emergency department. However, unscheduled persons requesting services for an emergency medical condition while presenting at another inpatient unit, clinic, or other ancillary area may also be subject to an emergency medical screening examination in accordance with EMTALA. Examination and treatment for emergency medical conditions or any such other service rendered to the extent required under EMTALA, will be provided to the patient and will qualify as emergency care. The determination that there is an emergency medical condition is made by the examining physician or other qualified medical personnel of PRMC as documented in the medical record. The determination that there is an urgent or primary medical condition is also made by the examining physician or other qualified medical personnel of PRMC as documented in the medical record.

**Non-Emergent, Non-Urgent Services:**
For patients who either (1) arrive to PRMC seeking non-emergent or non-urgent level care or (2) seek additional care following stabilization of an emergency medical condition, PRMC may provide elective services after consulting with PRMC's clinical staff and reviewing the patient's coverage options.

**Elective Services:**
Medical services that do not meet the definition of Emergent or Urgent above. Typically, these services are either primary care services or medical procedures scheduled in advance by the patient or by the health care provider (hospital, physician office, other).

**Locations where patients may present:**
All patients are able to seek emergency level services and urgent care services when they come to PRMC's emergency department or designated urgent care areas. However, patients with emergent and urgent conditions may also present in a variety of other locations, including but not limited to Labor and Delivery, ancillary departments, hospital clinics and other areas. PRMC also provides other elective services at the main hospital, clinics and other outpatient locations.

**DEFINITIONS:**

**Amounts Generally Billed (AGB):** The amount by which charges for uninsured patients are measured. Uninsured patients will not be charged more for emergency or other medically necessary care than the AGB for patients who have insurance.

**Episode of Care:** A defined period of illness that has a definite start and end date.

**Federal Poverty Guidelines (FPG):** Determined by the federal government of the United States and published annually in the Federal Register. FPG are based on the size of the family and family's income. FPG are used in determining a patient's eligibility for financial assistance under PRMC's financial assistance policy.

**Gross Charges:** Full, established price for medical care that the hospital consistently and uniformly charges all patients before contractual allowances, discounts or other deductions.

**Medical Indigency:** Patients who are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their family of household income or assets. Special circumstances may include catastrophic costs or conditions.

**Prompt Pay Discount-Lab:** A 50% discount of the patient's self-pay account balance (including any co-payment or deductible) if paid within 30 days of the statement date. This discount is an administrative adjustment and not considered financial assistance.

**Self-Pay Discount:** A percentage discount of the patient's self-pay account balance based on Uninsured status.

**Under Insured**: Those patients with insurance coverage unable to satisfy their out of pocket expenses.

**Uninsured**: A person who does not have insurance or third-party coverage who does not qualify for Medicaid or other state assistance. A patient may be classified as "uninsured" if the patient is insured, but the insurer refuses to pay for medical services rendered for reasons such as pre-existing conditions, out-of-network provider, etc.

**PROCEDURE:**

Peterson Regional Medical Center has a fiduciary duty to seek reimbursement for services it has provided from individuals who are able to pay, from third party insurers who cover the cost of care, and from other programs of assistance for which the patient is eligible. To determine whether a patient is able to pay for the services provided as well as to assist the patient in finding alternative coverage options if they are uninsured or underinsured, the hospital follows the following criteria related to billing and collecting from patients.

1. Collecting Information on Patient Health Coverage and Financial Resources
   A. Patient Obligations:
   Prior to the delivery of any health care services (except for cases that are an emergency or urgent care service level), the patient is expected to provide timely and accurate information on their insurance status, demographic information, changes to their family income or insurance status, and information on any deductibles or co-payments that are owed based on their existing insurance or financial program's payment obligations. The detailed information will include:
      (1) Full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, citizenship and residency information, and the patient's applicable financial resources that may be used to pay their bill;
      (2) Full name of the patient's guarantor, their address, telephone number, date of birth, social security number (if available), and their applicable financial resources that may be used to pay for the patient's bill; and
      (3) Other resources that may be used to pay their bill, including other insurance programs, motor vehicle or homeowners insurance policies if the treatment was due to an accident, worker's compensation programs, and student insurance policies, among others.

   It is ultimately the patient's obligation to keep track of and timely pay their unpaid hospital bill, including any existing co-payments, co-insurance, and deductibles. The patient is further required to inform either their current health insurer (if they have one) or the agency that determined the patient's eligibility status in a public health insurance program of any changes in family income or insurance status. The hospital may also assist the patient with updating their eligibility in a public program when there are any changes in Family Income or insurance status, but only if the hospital has been made aware by the patient of facts that may indicate a change in the patient's eligibility status.

   Patients are required to notify the state public program (e.g., Texas Medicaid Healthcare Partnership), information related to any lawsuit or insurance claim that will cover the cost of the services provided by the hospital within 10 days. A patient is further required to assign the right to a third party payment that will cover the costs of the services paid by the Texas Medicaid Healthcare Partnership or other government program.

   B. Hospital Obligations:
   Peterson Regional Medical Center will make all reasonable and diligent efforts to collect the patient insurance status and other information to verify coverage for the health care services to be provided by PRMC. These efforts may occur when the patient is scheduling their services, during pre-registration,

while the patient is admitted in the hospital, upon discharge, or during the collection process which may occur for a reasonable time following discharge from the hospital.

This information will be obtained prior to the delivery of any non-emergent and non-urgent health care services (i.e., elective procedures as defined in this credit and collection policy). PRMC will delay any attempt to obtain this information during the delivery of any EMTALA level emergency or urgent care services, if the process to obtain this information will delay or interfere with either the medical screening examination or the services undertaken to stabilize an emergency medical condition.

The hospital's reasonable and diligent efforts will include, but is not limited to, requesting information about the patient's insurance status, checking any available public or private insurance databases, and following the billing rules of a known third party payer. When the hospital's registration or admission staff are made aware of any such information, they shall also inform patients of their responsibility to inform the appropriate public program of any changes to family income or insurance status, including any lawsuit or insurance claim that may cover the cost of the services provided by the hospital.

If the patient or guarantor/guardian is unable to provide the information needed, and the patient consents, the hospital will make reasonable efforts to contact relatives, friends, guarantor/guardian, and the third party for additional information.

PRMC will also make reasonable and diligent efforts to investigate whether a third party resource may be responsible for the services provided by The hospital, including but not limited to: (1) a motor vehicle or homeowner's liability policy, (2) general accident or personal injury protection policies, (3) worker's compensation programs, (4) student insurance policies, among others. In accordance with applicable state regulations or the insurance contract, for any claim where PRMC's reasonable and diligent efforts resulted in a payment from a private insurer or public program, PRMC will report the recovery and off set it against the claim paid by the private insurer or public program. For state public assistance programs, the hospital is not required to secure assignment on a patient's right to a third party coverage on services provided due to an accident. In these cases the State of Texas will attempt to seek assignment on the costs of the services provided to the patient and which was paid for by Texas Medicaid Healthcare Partnership or other government payer.

The hospital further maintains all information in accordance with applicable federal and state privacy, security and ID theft laws.

B. Hospital Billing Practices

PRMC makes the same reasonable effort and follows the same reasonable process for collecting on bills owed by an uninsured patient as it does for all other patients. The hospital will first show that it has a current unpaid balance that is related to services provided to the patient and not covered by a private insurer or a financial assistance program. PRMC follows reasonable collection/billing procedures, which include:

(1) An initial bill sent to the patient or the party responsible for the patient's personal financial obligations, the initial bill will include information about the availability of a financial assistance program that might be able to cover the cost of the hospital's bill;
(2) Subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, or any other notification method that constitutes a genuine effort to contact the party responsible for the obligation and informs the patient of the availability of financial assistance;
(3) If possible, documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal service such as 'incorrect address' or 'undeliverable';
(4) Sending a final notice to those who are not enrolled in a public program (such as Texas Medicaid), where notices have not been returned by the United States Postal Service (e.g. "incorrect address" or "undeliverable."); and also notifying the patients of the availability of financial assistance in the communication;
(5) Documentation of continuous billing or collection action undertaken on a regular, frequent basis is maintained. Such documentation is maintained until audit review by a federal and/or state agency of the fiscal year cost report in which the bill or account is reported. For The federal Medicare program and the state HHSC for purposes of reporting, PRMC deems 120 days as appropriate period of time representing for continuous billing or collection actions.
(6) PRMC may use an extended business office vendor to assist in the collection practices as listed above

**Standard Collection Actions**

1. PRMC or its "Collection Vendors" will not undertake any "extraordinary collection activities" until such time as the hospital has made a reasonable effort and followed a reasonable review of the patient's financial status, which will determine that a patient is entitled to financial assistance or exemption from any collection or billing activities under this credit and collection policy. The hospital will keep any and all documentation that was used in this determination pursuant to the hospital's applicable record retention policy. Extraordinary collection activities may include lawsuits, liens on residences, arrests, body attachments, or as otherwise described below in compliance with state requirements.

2. The hospital or its "Collection Vendors" will not undertake collection action against an individual that has been approved for Medical Indigency per the hospital's Charity Care Policy.

3. PRMC will not garnish a Low Income Patient's (as determined by the Federal Poverty Income Level) or their guarantor's wages or execute a lien on the Low Income Patient's or their guarantor's personal residence or motor vehicle unless: (1) PRMC can show the patient or their guarantor has the ability to pay, (2) the patient/guarantor did not respond to hospital requests for information or the patient/guarantor refused to cooperate with the Hospital to seek an available financial assistance program.

4. The hospital and its agents shall not continue collection or billing on a patient who is a member of a bankruptcy proceeding except to secure its rights as a creditor in the appropriate order, provided that the state of Texas will file its own recovery action for those patients enrolled in a Texas assistance program. The hospital and its agents will also not charge interest on an overdue balance for a Low Income Patient or for patients who are low income based on the hospital's own internal financial assistance program.

5. PRMC maintains compliance with applicable billing requirements, including the Department of HHSC for non-payment of specific services or readmissions that the hospital determines was the result of a Serious Reportable Events (SRE). SREs that do not occur at the hospital are excluded from this.

**Outside Collection Agencies**

PRMC contracts with outside collection agencies to assist in the collection of certain accounts, including patient responsible amounts not resolved after issuance of hospital bills or final notices. However, as determined through this credit and collection policy, PRMC may assign such debt as bad debt at 120 days and later or charity care (otherwise deemed as uncollectible) prior to 120 days if it is able to determine that the patient was unable to pay following the hospital's own internal financial assistance program. Per IRS 501(r) regulations, a patient has 240 days after their first post-discharge billing statement for the previously provided care to get in any financial assistance applications in for consideration.

PRMC has a specific authorization or contract with the outside collection agencies and requires such agencies to abide by the hospital's credit and collection policies for those debts that the agency is pursuing. All outside collection agencies hired by PRMC will provide the patient with an opportunity to file a grievance and will forward to the hospital the results of such patient grievances. PRMC requires that any outside collection agency that it uses is governed by the State of Texas and that the outside collection agency also is in compliance with the Texas Attorney General's Debt Collection Regulations, as applicable

**Payment Collections and Arrangements**

PRMC will use the following guidelines for the collection process:

1. All self pay patients without insurance will receive a 30% discount at the time of billing. This will not apply to any self pay balances after insurance.
2. Any patient that goes to the Ambulatory Care Center or Kerrville Medical Plaza to receive lab work may receive a 50% discount if paid in full at the time of service or within the first 30 days of patient's first statement. Self pay patients with no insurance will receive the discount off the total charges and self pay balances after insurance will get the discount off of the balance after insurance has considered the claim.

<u>Self Pay Patients Presenting to the Emergency Department (No Insurance)</u>

- The Patient Access Specialist will screen the patient for Presumptive Charity per the Charity Care Policy
- If the patient qualifies, they will not be responsible for PRMC's bill for that date of service.
- If the patient does not qualify for presumptive charity, the Patient Access Specialist will request a deposit of $150 for Fast Track patients and $300 for ER patient at the time of discharge.
- If the patient cannot make a payment and does not qualify for presumptive charity, the Patient Access Specialist will give the patient PRMC's Financial Aid Application advising that the application and all required supporting documentation should be returned within 10 days for processing. If the patient has any questions regarding the application they may speak with a Financial Counselor at any time.

Insured Patients Presenting into the Emergency Department

- The Patient Access Specialist will verify the insurance and obtain ER benefits.
- The Patient Access Specialist will request any deductible, co-pay or co-insurance at the time of discharge.
- If the patient/guarantor cannot make payment and indicates they will be unable to make payment in the future the Patient Access Specialist will give the patient PRMC's Financial Aid Application, advising that the application and all required supporting documentation should be returned within 10 days for processing. If the patient has any questions regarding the application they may speak with a Financial Counselor at any time.

Self Pay Scheduled Procedures

- Patient Access will pre-register the patient prior to services.
- Patient Access will generate an estimate form for the scheduled exam/procedure and contact the patient to discuss financial obligations.
- Payment arrangements will be made with a Patient Access Specialist II or higher as follows:
    1. Payment in full prior to or at the time of service
    2. Pay in 2 equal payments with the first payment due prior to or at the time of service
    3. Pay in 3 equal payments with the first payment due prior to or at the time of service
    4. Pay in 4 equal payments with the first payment due prior to or at the time of service
    5. Payment plan with minimum monthly payments as per attachment and sign a promissory note .
- Patients unable to meet required payment arrangements will be referred to the hospitals in-house eligibility vendor to be screened for possible assistance through any county, state or federal programs.
- Patients who are screened by the hospitals in-house eligibility vendor and do not qualify for any assistance must complete PRMC's Financial Aid Application and return the completed application with all required supporting documentation prior to the date of service. If the patient has any questions regarding the application they may speak with a Financial Counselor at any time.
- Accounts in which the patient is non-compliant with the completion of the financial aid application and/or screening process will be referred to the Patient Access Director or his/her designee for further review.
    1. If the exam/procedure is medically necessary, per the physician, services will be performed without additional financial discussions prior to services being rendered.
    2. If the exam is not medically necessary, per the physician, services will be rescheduled until such time as the patient makes adequate financial arrangements or completes the screening process.

Insured Scheduled Procedures

- Patient Access will pre-register, verify insurance eligibility, and obtain insurance benefits and pre-certification prior to services.
- Based on insurance benefits obtained Patient Access will generate an estimate form for the scheduled exam/procedure and contact the patient to discuss financial obligations. The Patient Access Specialist will request payment for any deductibles, co-payments or co-insurance amounts.
- Payment arrangements will be made with a Patient Access Specialist II or higher as follows:
    1. Payment in full prior to or at the time of service
    2. Pay in 2 equal payments with the first payment due prior to or at the time of service
    3. Pay in 3 equal payments with the first payment due prior to or at the time of service
    4. Pay in 4 equal payments with the first payment due prior to or at the time of service
    5. Payment plan with minimum monthly payments as per attachment and sign a promissory note.
- Patients unable to meet required payment arrangements will be referred to the hospitals in-house eligibility vendor to be screened for possible assistance through any county, state or federal programs.

- Patients who are screened by the hospitals in-house eligibility vendor and do not qualify for any assistance must complete PRMC's Financial Aid Application and return with all required supporting documentation prior to the date of service. If the patient has any questions regarding the application they may speak with a Financial Counselor at any time.
- Accounts where the patient is non-compliant with the completion of the financial aid application and/or screening process will be referred to the Patient Access Director or his/her designee for further review.
    1. If the exam/procedure is medically necessary, per the physician, services will be performed without additional financial discussions prior to services being rendered.
    2. If the exam is not medically necessary, per the physician, services will be rescheduled until such time as the patient makes adequate financial arrangements or completes the screening process.

Self Pay Direct Admits

- PRMC's in-house eligibility vendor will screen patients within 24 hours of admission for any possible assistance through any county, state or federal programs.
- If the patient will not qualify for assistance, the in-house eligibility vendor will notify a Patient Access Specialist or Financial Counselor. The Patient Access Specialist or Financial Counselor will screen the patient for presumptive charity. If the patient qualifies for presumptive charity then the patient will not be responsible to PRMC's bill. If the patient looks to qualify but PRMC will need additional information, the patient will be contacted by a Patient Access Specialist or Financial Counselor during their hospital stay. The Patient Access Specialist or Financial Counselor will present a detailed estimate form of charges accumulated to date and a Financial Aid Application.
- The Patient Access Specialist or Financial Counselor will ask for a $1,000 deposit per day and request the patient sign the estimate form.
- If the patient is unable to make the required deposit or any type of deposit the patient will be given a Financial Aid Application and asked to complete and return with all required supporting documentation within 10 days of discharge for processing. If the patient has any questions regarding the application they may speak with a Financial Counselor at any time.

Insured Direct Admits

- Patient Access will verify insurance eligibility, obtain insurance benefits and all required insurance authorizations within 24 business hours of admission.
- A Patient Access Specialist will visit the patient during their hospital stay to review their insurance benefits and discuss financial obligations. The Patient Access Specialist will request payment for any deductibles, co-payments or co-insurance amounts.
- Payment arrangements will be made with a Patient Access Specialist II or higher as follows:
    1. Payment in full prior to or at the time of service
    2. Pay in 2 equal payments with the first payment due prior to or at the time of service
    3. Pay in 3 equal payments with the first payment due prior to or at the time of service
    4. Pay in 4 equal payments with the first payment due prior to or at the time of service
    5. Payment plan with minimum monthly payments as per attachment and sign a promissory note.
- If the patient is unable to make adequate payment arrangements PRMC's Financial Aid Application will be given with instructions to return the completed application and all required supporting documentation within 10 days of discharge for processing. If the patient has any questions regarding the application they may speak with a Financial Counselor at any time.

Self Pay Unscheduled/Diagnostic Procedures/Services

- Patient Access will generate an estimate of charges based on the physician's order.
- Payment arrangements will be made with a Patient Access Specialist II or higher as follows:
    1. Payment in full prior to or at the time of service.
    2. Pay in 2 equal payments with the first payment due prior to or at the time of service
    3. Pay in 3 equal payments with the first payment due prior to or at the time of service
    4. Pay in 4 equal payments with the first payment due prior to or at the time of service
    5. Payment plan with minimum monthly payments as per attachment and sign a promissory note.
- Patients unable to meet required payment arrangements will be referred to the hospitals in-house eligibility vendor to be screened for possible assistance through any county, state or federal programs.
- Patients who are screened by the hospitals in-house eligibility vendor and do not qualify for any assistance must complete PRMC's Financial Aid Application and return with all required supporting documentation prior to the services being rendered. If the patient has any questions regarding the application they may speak with a Financial Counselor at any time.
- Accounts in which the patient is non-compliant with the completion of the financial aid application and/or screening process will be referred to the Patient Access Director or his/her designee for further review.
    1. If the exam/procedure is deemed medically necessary, per the physician, services with be performed without additional financial discussions prior to services being rendered.
    2. If the exam is not deemed medically necessary, per the physician, services will be delayed until such time as the patient makes adequate financial arrangements or completes the screening process.

Insured Unscheduled/Diagnostic Procedures/Services

- Patient Access will register, verify insurance eligibility, and obtain insurance benefits and authorization as required.
- Patient Access will generate an estimate of charges based on the physician's order.

Payment arrangements will be made with a Patient Access Specialist II or higher as follows:

1. Payment in full prior to or at the time of service
2. Pay in 2 equal payments with the first payment due prior to or at the time of service
3. Pay in 3 equal payments with the first payment due prior to or at the time of service
4. Pay in 4 equal payments with the first payment due prior to or at the time of service
5. Payment plan with minimum monthly payments as per attachment and sign a promissory note.

- Patients unable to meet required payment arrangements will be referred to the hospitals in-house eligibility vendor to be screened for possible assistance through any county, state or federal programs.
- Patients who are screened by the hospitals in-house eligibility vendor and do not qualify for any assistance must complete PRMC's Financial Aid Application and return the application with all required supporting documentation prior to the services being rendered. If the patient has any questions regarding the application they may speak with a Financial Counselor at any time.
- Accounts in which the patient is non-compliant with the financial and/or screening process will be referred to the Patient Access Director or his/her designee for further review.
    1. If the exam/procedure is deemed medically necessary, per the physician, services will be performed without additional financial discussions prior to services being rendered.
    2. If the exam is deemed not medically necessary, per the physician, services will be delayed until such time as the patient can make adequate financial arrangements or completes the screening process.

**Hospital Financial Assistance Programs**

Patients who are eligible for enrollment in any county, state or federal public assistance program, (e.g. county indigent, Texas Medicaid), are automatically deemed to be enrolled in a financial assistance program. For all patients that are enrolled in these state public assistance programs, the hospital may only bill those patients for the specific co-payment, co-insurance, or deductible that is outlined in the applicable plan provisions.

PRMC will seek a specified payment for those patients that do not qualify for enrollment in a Texas state public assistance program, such as out of state residents, but who may otherwise meet the general financial eligibility categories of state public assistance program. For these patients, the payment amount will be set at:

The hospital's Medicare rate or the average of its three best negotiated commercial rates, whichever is more (approximately 30% discount).

**Populations Exempt from Collection Activities**

The following individuals and patient populations are exempt from any collection or billing procedures pursuant to state regulations and policies:
1. Patients enrolled in a public health insurance program, including but not limited to, Texas Disabled and Children's program, "low Income patients" as determined by the Office of Medicaid- subject to the follow exceptions:
a. The hospital may seek collection action against any patient enrolled in the above mentioned programs for their required co-payments and deductibles that are set forth by each specific program;
b. PRMC may also initiate billing or collection for a patient who alleges that he or she is a participant in a financial assistance program that covers the costs of the hospital services, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in a financial assistance program, (including receipt or verification of signed application) PRMC shall cease its billing or collection activities.
c. PRMC may seek collection action against any of the patients participating in the programs listed above for non-covered services that the patient has agreed to be responsible for, provided that the hospital obtained the patient's prior written consent to be billed for the service.

**Presumptive Charity Eligibility**

Peterson Regional Medical Center understands that certain patients may be unable to complete a financial assistance application, comply with requests for documentation, or are otherwise non-responsive to the application process. As a result, there may be circumstances under which a patient's qualification for financial assistance is established without completing the formal assistance application. Under these circumstances, PRMC may utilize other sources of information to make an individual assessment of financial need. This information will enable PRMC to make an informed decision on the financial need of non- responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

PRMC may utilize a third-party to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and

liquidity. The electronic technology is designed to assess each patient to the same standards and is calibrated against historical approvals for PRMC financial assistance under the traditional application process.

The electronic technology will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows PRMC to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy.

**REFERENCE:**

Please see PRMC's Charity Care Policy for more details on this program: Charity Care Policy

**Effective Date:** **May 29, 2015**

**Approval Date:**