



Russell Medical Center Policy and Procedure

SUBJECT: Billings and Collections

RECOMMENDATION: Business Office Director

APPROVAL:

EFFECTIVE DATE: 01-01-26

Purpose:

This policy, along with Russell Medical's ("Hospital") Financial Assistance Policy ("FAP"), is intended to meet the requirements of applicable federal, state, and local laws, including without limitation, section 501 (r) of the Internal Revenue Code as amended, and the regulations thereunder. This policy establishes actions that may be taken in the event of nonpayment for medical care provided by Hospital, including collection actions and reporting to credit agencies.

Collections Process:

The collections process starts at time of registration for all scheduled patients and after the medical screening has been completed for patients admitted through the Emergency Department. This process ends at the time of final settlement of balances due to the Hospital for services provided.

Definitions:

Amounts Generally Billed ("AGB") – For medical care provided to a patient eligible for financial assistance under this policy, Hospital's gross charges for the care provided to the individual multiplied by a percentage of gross charges ("AGB Percentage"). Hospital calculates its AGB Percentages using the look-back method. The method divides (1) the sum of all claims for emergency and other medically necessary care that have been allowed by Medicaid, Medicare fee-for-service and all private health insurers that pay claims to the Hospital during a prior 12-month period by (2) the sum of the associated gross charges for those claims. All discounts outlined in this FAP shall apply to AGB for the care provided and not gross charges. Hospital's current AGB Percentage and a description of the calculation may be readily obtained free of charge from the Patient Financial Services Department that is located at 125 Alison Drive, Suite 5, Alexander City, AL and may be contacted at 256-329-7136.

EMTALA – The Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) and the regulations there, including specifically 42 CFR § 489.24 (or any successor regulations).

Extraordinary Collection Actions ("ECA") – ECA's include:

1. Selling an individual's debt to another party ("Purchaser") unless the Purchaser has entered into a prior written agreement (i) prohibiting the Purchaser from engaging in any ECAs to obtain payment for care, (ii) prohibiting the Purchaser from charging interest in excess of the rate set forth in I.R.C. § 6621 (a)(2) at the time the debt is sold, (iii) requiring the return to or recall by Hospital upon a determination that the individual is FAP eligible individual, and (iv) if the debt is not returned to or recalled by Hospital for a FAP eligible individual, requiring the Purchaser to adhere to procedures specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the Purchaser and the Hospital together more than he or she is personally responsible for paying under the FAP.
2. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.



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3. Deferring or denying, or requiring payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the Hospital's FAP.
4. Any actions that require a legal or judicial process, including but not limited to (i) placing a lien on an individual's property (other than liens permitted under state law on personal injury settlements related to the care), (ii) foreclosure on an individual's property, (iii) attaching or seizing an individual's bank account or any other personal property; (iv) commencing a civil action against an individual, (v) causing an individual's arrest, (vi) causing an individual to be subject to a writ of body attachment; or (viii) garnishing an individual's wages. For this purpose, the filing of a claim in any bankruptcy proceeding is not an ECA

Procedures:

1. At the time of registration and after all EMTALA requirements are met, patients will be asked to make a payment for an estimate of their co-pay and or deductibles. Patients with third party coverage that cannot make the payment will be referred to the Patient Financial Services Department who will follow the FAP as appropriate. Patients with no third party coverage will be referred to the Patient Financial Services Department who will follow the FAP. A plain language summary of the FAP shall be made available upon request.
2. Subsequent to the discharge and the appropriate time for all charges to be entered and completion of coding by the Health Information Management staff, all claims will be billed to the third party payor obtained from the patient at time of registration. Patients with commercial or government insurance will be mailed their first statement once the claim is processed by the payor. The first statements will clearly identify total charges and all adjustments and payments. All subsequent statements will be mailed to the patient every thirty (30) days. These statements will clearly identify total charges and all subsequent adjustments and payments to give patients a clear understanding of their personal obligation.
3. Each billing statement shall notify and inform recipients about the availability of financial assistance under the FAP and include the telephone number of the Patient Financial Services Department that can provide information about the FAP and FAP application process and the direct web address where copies of the FAP, FAP application, and the plain language summary of the FAP may be obtained. Patients who do not have insurance, regardless of whether they qualify for additional financial assistance as set forth in the FAP, will at least be given an uninsured discount equivalent to the discounts given to third party insurers so that no such patient is charged more than the AGB. For those patients that qualify for financial assistance, Hospital will provide additional financial assistance as set forth in the FAP.
4. The Patient Financial Services Department is the department of the Hospital with the authority and responsibility for determining whether an individual qualifies for financial assistance or whether an ECAs may be initiated against individuals.



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MEMBER OF **UAB** HEALTH SYSTEM

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5. In compliance with section 9 of this policy, balances that remain unpaid may be referred to an external collection agency that will complete the collection process. Such collection agency shall be obligated by written contract to observe the same procedures with respect to determining qualification for financial assistance that apply to Hospital under the FAP. Those efforts will include a continuation of statements and phone calls as deemed appropriate. In the event that these efforts are inadequate, the external agency may also report the unpaid balances to credit bureaus and/or undertake other ECAs. All staff assigned to work for the hospital at the contracted external collection agency will be aware of the Hospital's FAP and offer that to patients when appropriate.
6. Hospital has adopted an "Early-Out" program designed as an extension of the Patient Financial Services Department. This program is not considered an ECA. Accounts will be referred to this program once they become eligible for a statement.
7. The Early-Out agency will send a series of billing statements on a thirty (30) day cycle. In addition to the billing statement, they will also attempt to call each patient and/or payor as deemed appropriate. Collection efforts in the Early-Out phase will last up to one hundred and twenty (120) days from the end of the hospital's internal billing cycle of sixty (60) days. If the accounts remain unpaid at that time, they are sent back to Hospital's Patient Financial Services Department to be written off to bad debt and assigned to a bad debt collection agency or the initiation of any other ECAs as permitted by this policy.
8. Accounts written off to bad debt and assigned to one of the approved bad debt collection agencies after all collection efforts are exhausted as described previously and the applicable time period as set forth below has elapsed. Bad debt collection efforts will include a series of letters, phone calls, texts as deemed appropriate, reporting to the credit bureaus, and other ECAs.
9. Notwithstanding the provisions of the preceding paragraphs, the following limitations shall apply:
 - a. During the first one hundred and eighty (180) days after the patient's first billing statement for care is issued, Hospital shall not refer the account to a collection agency or engage in any other ECAs.
 - b. Hospital shall observe all patient notification procedures set forth in the FAP.
 - c. If no positive patient response is received after one hundred and eighty (180) days from the first billing statement, Hospital shall characterize the unpaid balance as bad debt and may proceed with the collection efforts or any other ECAs described in this policy.
 - d. Notwithstanding bad debt classification or referral to a collection agency or initiation of another ECA, a patient may apply for financial assistance using the process outlined in the FAP for an additional sixty (60) days, for a total application period of two hundred and forty (240) days from the first billing statement.
 - e. All ECAs will be put on hold as soon as a FAP application is received and up until determination is made for eligibility. After FAP applications are processed, patients will be notified in writing as to whether they qualify for financial assistance in accordance with the FAP.
 - f. The Hospital will continue to accept and process FAP applications during the full 240-day application period even if the account has been referred to collections.



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- g.** At least thirty (30) days before initiating ECA, Hospital shall (1) provide the patient with a written notice indicating the availability of financial assistance for eligible patients, identifying the ECAs that the Hospital may take to obtain payment for care, and stating the deadline after which ECAs may be initiated; (2) provide a plain language summary of the FAP; (3) make a reasonable effort to orally notify the patient about the FAP and how to obtain assistance with the FAP application process.
10. If, based on information other than that provided by the individual or based on a prior FAP-eligibility determination, a patient is presumptively determined to be eligible for less than the most generous assistance available under the FAP, Hospital shall:
- a.** Notify the individual regarding the basis for the presumptive FAP-eligibility determination and the way to apply for more generous assistance available under the FAP.
 - b.** Give the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care.
 - c.** Determine whether the individual is eligible for a more generous discount upon the receipt of a complete FAP application for financial assistance.
11. Hospital will not accept a waiver of the foregoing procedures of any signed statement that the individual does not wish to apply for assistance under the FAP or receive the information about the FAP described in this policy and the foregoing procedures will apply in all events.
12. In addition to the previous efforts, the FAP, FAP application, and a plain language summary of the FAP shall be available free of charge on the Hospital's website. Additionally, paper copies of the FAP, FAP application, and a plain language summary of the FAP shall be available upon request and free of charge in public locations in the Hospital (including each registration desk throughout the Hospital and the emergency room) or by contacting the Patient Financial Services Department at 256-329-7136.

Related Documents:

1. Financial Assistance, Russell Medical
2. EMTALA and Emergency Medical Care, Russell Medical Hospital policy
3. Financial Assistance Application