MEMORIAL HOSPITAL AT GULFPORT
BUSINESS OFFICE
POLICY AND PROCEDURE

BOARD APPROVED 10/18/21 DATE

UNIT: Patient Financial Services Revenue Cycle Management
SUBJECT: Billing Compliance Policy Billing/Collection Policy
APPROVED BY: MHG BOARD OF TRUSTEES
EFFECTIVE DATE: October 2022

I. POLICY

Memorial Hospital at Gulfport 's Patient Financial Services Department (PFS) is committed to billing in compliance with all applicable laws, rules, regulations, 501(r) of the IRS, and policies established by federal and state government, federal healthcare programs like Medicare and Medicaid and private payors.

- All billing for patient services is properly documented and processed according to PFS policies and procedures
- PFS employees are responsible to promptly report any actual or suspected billing or payment errors to their immediate supervisor. Each PFS employee is responsible for taking steps to prevent, detect, correct, and report actual or suspected fraudulent acts or abuses of discretion associated with billing procedures.
- Any employee who in "good faith" reports acts/suspected acts of fraud and abuse, violations of the Hospital's Corporate Compliance Program, and other misconduct under the protection of the federal False Claims Act (31 U.S.C. §§ 3729-3733) will not be fired, harassed or coerced to resign for filing such report. The Hospital does not permit retaliation against any employee who submits a good faith report of actual or suspected employee or vendor misconduct.
- The Hospital and PFS Department require that contractors and agents also comply with the laws described in this policy/procedure. Contractors and agents of the PFS Department include independent parties who perform billing, collection, or coding functions on behalf of or in concert with the PFS personnel.

II. PURPOSE

It is the goal of this policy to provide clear consistent guidelines for conducting billing and collections functions to ensure and promote compliance and to make reasonable efforts to inform patients of their financial responsibilities, and to make reasonable efforts to determine a patient's eligibility for financial assistance under Memorial Hospital at Gulfport's financial assistance policy before engaging in extraordinary collection actions. In addition to providing information about the False Claims Acts and other relevant laws and regulations, this policy establishes a couple of key concepts:

- PFS employees, contractors, and/or vendors who perform services on behalf of or along with the PFS staff are accountable for an accurate charging, billing, and collection process and are expected to perform job functions in compliance with applicable laws and regulations and hospital policies.
- PFS employees are responsible to monitor billing practices and report instances of actual or suspected erroneous billing to their immediate supervisor.

III. GENERAL GUIDELINES

By adhering to the following guidelines, billing in compliance with the laws described in this document can be enhanced. These guidelines, however, should not be viewed as providing an answer for all situations. Whenever a question arises concerning the propriety of a certain course of conduct, guidance should be sought from PFS Department management, the Senior Vice President/CFO, the Chief Administrative Officer, the Chief Compliance Officer, or any member of the Corporate Compliance Committee.

A. PFS staff will ensure that charges accurately represent the care, services, and supplies provided to patients.
   1. Charges, corrections, and credits must be submitted in accordance with PFS policies and guidelines.
   2. Charges requiring CPT/HCPCS codes must be coded in accordance with government guidelines. Coding practices will be reviewed annually by PFS Management to ensure compliance with current coding guidelines.
   3. Department personnel will promptly report and return overpayments received as a result of erroneous or fraudulent billing.
   4. Department personnel will monitor CMS publications to stay current with billing guidelines.

B. PFS staff are responsible for processing claims based on CMS and payer edits. Staff are required to report inaccurate, incomplete, fraudulent or false billing practices (including self-disclosure) to their manager, supervisor or team leader.

C. PFS monitors billing activities in order to detect deliberate or accidental occurrences of incorrect billing and correct problems, refund incorrectly paid amounts, and report errors. PFS Management will monitor systems for inappropriate, inaccurate, fraudulent or false billing practices.

D. PFS Management will review reports from the current billing software and other internal sources. Any questionable or suspicious findings will be promptly referred to the Chief Administrative Officer, Chief Financial Officer and the Chief Compliance Officer.

E. The PFS Billing Supervisor will monitor individual employee billing records and audit completed work for each PFS employee on a quarterly basis. More frequent and comprehensive reviews and audits will be initiated if needed based on the results of the routine monitoring. If inaccuracies are discovered during routine audits, immediate feedback and education will be provided to the employee, and additional training, disciplinary action (if required), and corrective action will be initiated.

F. PFS Management will notify the Chief Administrative Officer and Chief Financial Officer (CFO) of any possible noncompliant situation (actual or potential) that resulted in an inappropriate receipt of governmental funds. Appropriate notifications and a refund will be initiated under the CFO's direction.

PFS Management, in coordination with the Financial Counselors, will adhere to the hospital's Financial Assistance Policy by making reasonable effort to provide notification on financial assistance availability for eligible individuals. Collection on unpaid post discharge medical debt and initiation of one or more extraordinary collection actions (ECA) shall begin no earlier than 30 days post discharge,

FEDERAL FALSE CLAIMS ACT (31 U.S.C. §§ 3729-3733)

A. The federal False Claims Act (FCA) establishes liability when any person or entity improperly receives from or avoids payment to the United States government. The FCA authorizes federal prosecutors to

file a civil action against any person or entity that "knowingly files" a false claim with a federal health care program, including Medicare or Medicaid.

B. The FCA applies to all Hospital employees and all other persons and entities, including Hospital contractors and agents, who:

1. Knowingly submits a false or fraudulent claim for payment to the United States government;
2. Knowingly make or use a false record or statement in order to get a false or fraudulent claim paid by the United States government;
3. Conspire with others to get a false or fraudulent claim paid; or
4. Knowingly make any false record or false statement in order to avoid or decrease an obligation to pay the government.

C. Anyone who violates the FCA is liable for civil penalties, plus three times the amount of the damages the government sustains. The government may also exclude "violators" from participating in Medicare, Medicaid, and other government programs. Any person or entity that makes an intentional submission of a false claim is also subject to federal criminal enforcement.

D. The FCA authorizes private persons to: (1) sue persons or entities who knowingly presented the government with false or fraudulent claims, and (2) share in any proceeds ultimately recovered as a result of the suit. The FCA includes provisions which protect these individuals from discharge, harassment or other employment-related discrimination as a result of their reports of violations of the FCA.

E. The FCA includes a provision that reduces penalties for providers who promptly self-disclose a suspected FCA violation. This self-disclosure protocol allows providers to conduct their own investigations, take appropriate corrective measures, calculate damages, and submit the findings that involve more serious problems to the agency.

EXTRAORDINARY COLLECTION ACTIONS (ECA)

A. According to the department of Internal Revenue Service and Treasury, Extraordinary Collection Actions (ECA) is defined as any actions that the hospital, its contractors and/or vendors, may take related to obtaining payment of a bill for medical care, including, but not limited to, any extraordinary collection actions (ECA). This includes obtaining payment of a bill on individuals who may qualify for financial assistance. The hospital will provide 120-day notification period beginning on the first discharge billing statement to dispute the debt.

B. Section 501(r)(6) requires a hospital organization to make reasonable efforts to determine whether an individual is eligible for assistance under the hospital organization's financial assistance policy (FAP) before engaging in ECAs against the individual. The hospital will utilize solicitation by third party vendors attempting to collect the debts and will notify patients they have 240 days after the first discharge billing statement to apply for assistance before ECAs are taken.

C. Third party agencies representing the hospital follow the hospital policies related to ECAs and reasonable efforts.

D. ECAs are actions taken by a hospital facility against an individual related to obtaining payment of a bill for medical care covered under the FAP such as:

- Involve selling an individual's debt to another party (MHG does not allow)
- Involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, "credit agencies") (MHG does allow)
- Involve deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's non-payment of one or more bills for

previously provided care covered under the hospital facility's FAP (MHG does not allow)
- Require a legal or judicial process (MHG does allow)

1. Examples of actions that may require a legal or judicial process include, but are not limited to:
   - Placing a lien on an individual's property (MHG does not allow)
   - Foreclosing on an individual's real property (MHG does not allow)
   - Attaching or seizing an individual's bank account or any other personal property (MHG does not allow)
   - Commencing a civil action against an individual (MHG does allow)
   - Causing an individual's arrest (MHG does not allow)
   - Causing an individual to be subject to a writ of body attachment (MHG does not allow)
   - Garnishing an individual's wages (MHG does allow)

2. A claim filed by a hospital facility in any bankruptcy proceeding is not an ECA. Also, a lien placed on the proceeds of a judgement, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries caused by a third party for which the hospital facility provided care is not an ECA.

David White, Chairman
Board of Trustees, MHG

10/18/21
Date

Kent G. Nicaud
President/CEO, MHG

10/18/21
Date