59A-5.032 Price Transparency and Patient Billing.

(1) Website. Each center shall make available to patients and prospective patients price transparency and patient billing information on its website regarding the availability of estimates of costs that may be incurred by the patient, financial assistance, billing practices, and a hyperlink to the Agency's service bundle pricing website. The content on the center's website shall be reviewed at least every 90 days and updated as needed to maintain timely and accurate information. For the purpose of this rule, service bundles means the reasonably expected center services and care provided to a patient for a specific treatment, procedure, or diagnosis as posted on the Agency's website. In accordance with Section 395.301, F.S., the center's website must include:

(a) A hyperlink to the Agency's pricing website upon implementation of the same that provides information on payments made to the facilities for defined service bundles and procedures. The Agency's pricing website is located at: http://pricing.floridahealthfinder.gov;

(b) A statement informing patients and prospective patients that the service bundle information is a non-personalized estimate of costs that may be incurred by the patient for anticipated services and that actual costs will be based on services actually provided to the patient;

(c) A statement informing patients and prospective patients of their right to request a personalized estimate from the center;

(d) A statement informing patients of the center's financial assistance policy, charity care policy, and collection procedure;

(e) A list of names and contact information of health care practitioners and medical practice groups contracted to provide services within the center, grouped by specialty or service; and,

(f) A statement informing patients to contact the health care practitioners anticipated to provide services to the patient while in the center regarding a personalized estimate, billing practices and participation with the patient's insurance provider or health maintenance organization (HMO) as the practitioners may not participate with the same health insurers or HMO as the center.

(2) Estimate. The center shall provide an estimate upon request of the patient, prospective patient, or legal guardian for nonemergency medical services.

(a) An estimate or an update to a previous estimate shall be provided within 7 business days from receipt of the request. Unless the patient requests a more personalized estimate, the estimate may be based upon the average payment received for the anticipated service bundle. Every estimate shall include:

1. A statement informing the requestor to contact their health insurer or HMO for anticipated cost sharing responsibilities,

2. A statement advising the requestor that the actual cost may exceed the estimate,

3. The web address to financial assistance policies, charity care policy, and collection procedure,

4. A description and purpose of any facility fees, if applicable,

5. A statement that services may be provided by other health care providers who may bill separately,

6. A statement, including a web address if different from above, that contact information for health care practitioners and medical practice groups that are expected to bill separately is available on the center's website; and,

7. A statement advising the requestor that the patient may pay less for the procedure or service at another facility or in another health care setting.

(b) If the center provides a non-personalized estimate, the estimate shall include a statement that a personalized estimate is available upon request.

(c) A personalized estimate must include the charges specific to the patient's anticipated services.

(3) Itemized statement or bill. The center shall provide an itemized statement or bill upon request of the patient or the patient's survivor or legal guardian. The itemized statement or bill shall be provided within 7 business days after the patient's discharge or release, or 7 business days after the request, whichever is later. The itemized statement or bill must include:

(a) A description of the individual charges from each department or service area by date, as prescribed in subsection 395.301(1)(d), F.S.;

(b) Contact information for health care practitioners or medical practice groups that are expected to bill separately based on services provided; and,

(c) The center's contact information for billing questions and disputes.

Rulemaking Authority 395.301 FS. Law Implemented 395.301 FS. History–New 2-19-18.

AdventHealth Surgery Center Ormond Beach AdventHealth Surgery Center Port Orange		
SUBJECT: PATIENT FINANCIAL RESPONSIBILITIES		
POLICY: BO-26	**EFFECTIVE DATE:**	**DATE REVISED: 7-2023**

PURPOSE

To support the rights of patients in understanding financial issues and their financial responsibilities

POLICY

A. All patients are informed of the facility's policy regarding payment of services.

B. Patients may receive an estimate and explanation of fees for proposed plan of treatment. The patient will be informed of any deductible and/or copayment prior to procedure. Facility policy requires that this patient responsibility is paid in advance of procedure unless other arrangements have been made.

C. Special payment arrangements must be approved by the Administrator and Executive Director.

D. Unless payment in full for procedure is obtained in advance, the patient will be required to assign all insurance/Medicare payments to be paid directly to the facility.

E. Patients will receive a Statement of Charges within 7 days after DOS regardless of source of payment.

PROCEDURE

A. When a patient has decided to undergo treatment, the patient's insurance benefits will be verified. If a deposit is required, it is collected, documented, and a receipt given to the patient.

B. At the time of pre-admission or admission, the patient will sign an Authorization for Insurance/Medicare Benefits form assigning all insurance/Medicare payments to be paid directly to the facility.

C. The Administrator and Executive Director reviews requests for special payment arrangements and documents specific arrangements for satisfying charges.

D. The insurance verification and/or financial counselor staff are responsible for entering notes regarding promissory notes or other pertinent billing/insurance information received from the patient into software billing module.

AdventHealth Surgery Center Ormond Beach AdventHealth Surgery Center Port Orange		
SUBJECT: COLLECTIONS Page 1 of 4		
POLICY: BO-30	**EFFECTIVE DATE:**	**DATE REVISED: 7-2023**

PURPOSE
To describe parameters for appropriate collections activity

POLICY
A. The Center's business office staff will perform billing and collection services for the Surgery Centers.

B. Collection activities should be governed by the following standards:
   1. Every account with an outstanding balance should be followed up (and the follow up documented in the computer system) at least every 30 days.
   2. Accounts should be worked by priority of age and value.
   3. Accounts receivable days should be maintained at less than 55 days in receivable on average. (To calculate days in A/R take the last 3 months net revenue, divide by the total calendar days in that time to get the average net revenue per day, then take the total net A/R for the current month end and divide by the average net revenue per day.)
   4. Accounts receivable over 120 days should be no more than 10% of the total A/R balance.
   5. Fair Debt Collection Practices and professionalism should be observed in all collection communications.

PROCEDURES
General
A. Print reminder notes from the computer system for the day. Prioritize and perform the appropriate action whether that is a call to a patient or insurance company, sending a statement or letter to the patient, or re-filing insurance (correcting information as needed). Other possible actions include placing the account on the Bad Debt Write Off list, performing a small balance write off (if the account is less than $10), or placing the account on the Collection Agency Turnover list for the administrator to review.

B. Follow up on the previous day's activities to assure faxes were received, telephone calls were returned, etc.

C. Review list of accounts receivable by payer, so that more than one outstanding insurance balance can be worked during one contact.

D. All actions taken should be documented in the computer system. The account should not be considered "worked" unless some action that will move the account toward resolution has taken place.

E. Each contact should be a new memo that includes the date, the person with whom you spoke, the results of the discussion, a future follow up date dictated by the resolution achieved, and your initials. Abbreviations should be used but only those agreed upon and documented by the business office coordinator.

F. ***Insurance***
   1. If the insurance company representative states that the claim has been paid but the check has not yet been received, verify the mailing address and tax identification number, obtain the date of the check, the check number and amount. The payment may have been posted in error to another account.

2. The insurance collections process should begin at 35 days after the claim was filed. The collector should place a call to the insurance company to determine the status of the claim. If the claim is in process, ask for an estimated payment date and enter a follow up note for that date in the tickler system.

3. If the claim has not been received, ask if it can be faxed. If you fax a claim, follow up with a telephone call to verify it was received. Again, enter a follow up note in the tickler system.

4. If the claim is in review, determine what information is required to satisfy the review. If it is physician notes or any other item that you can obtain from the patient's chart, fax the information to the claim reviewer and ask for an estimate of when payment will be made.

5. If the claim has been denied, ask why. If it is a documentation problem, work with the coder or whoever can assist to get the claim re-filed and paid.

6. If the claim is denied for timely filing, verify this is valid in our contract with the payer. If so, add it to the list of accounts to be written off for the business office coordinator to review.

7. Medicare or any other claims that are filed electronically should be reviewed at 20 days after the claim was filed.

8. Do not hesitate to contact the plan's Provider Representative if you believe the claim processing is being delayed without reason.

9. Diligent follow up is critical to avoid claims denied due to filing after the carrier's established timely filing window.

10. Finally, enlist the patient's assistance in getting their claim processed. We file the claim with their insurance company as a service to them, however, our relationship and contract is with the patient, not the insurer. Patient calls to their insurance company can be very effective in getting a delayed claim paid.

G. ***Patient Collections/Statements/Dunning Letters***

1. Patient statements should have standard dunning messages based on the age and status of the claim. Some possible options, depending on how your computer system ages the accounts, how it determines the need for a statement and how it handles patient vs. insurance balances are:
    a. 30 Days Old – We have filed your insurance claim for you.
    b. 60 Days Old – Your insurance has not paid your claim. Please contact your insurance carrier.
    c. 90 Days Old -- Your insurance has still not paid. Please contact our billing office to discuss payment of your claim.

d. Over 90 Days Old – For claims more than 90 days old, begin sending one of the standard dunning letters as appropriate to the situation. See the following sample dunning letters that may be used. Note: Confidentiality must be observed when sending dunning letters. Assure that only the name and address show through if window envelopes are used. The envelope must be sealed.

e. Over 120 Days Old – All accounts over 120 days old should be referred to the business office coordinator for review and possible turnover to a collections agency. Exceptions to this action include Medicare/Medicaid, CHAMPUS, Worker's Compensation and some HMO accounts.

2. Per Florida regulations an initial post-treatment statement will be sent seven (7) days after the DOS.
   a. This statement will prominently display the Center's patient liaison name and telephone number.
   b. If the patient requests their medical record to verify the charges, the Center must send the medical record to the patient within 10 days from the request.
   c. If the patient has any questions regarding their statement or bill, the Center is required to respond within seven (7) days after the date a question is received.

3. Subsequent patient statements should be sent at least monthly, or upon the various "triggers" your computer system may use.

H. ***Insufficient Funds/Bankruptcy/Litigation/Caveats***

1. When a patient's check is returned from the bank for insufficient funds, the patient should be contacted immediately. Verify with your bank that they attempted to clear the check twice. When you call the patient, offer them the opportunity to clear the past due amount immediately by credit card payment, which can be taken over the telephone, by money order (set a date for receipt and follow up), by cashier's check or by bringing cash to the Center.

2. Bankruptcy notices require immediate attention. Prompt filing with the bankruptcy court is very important. Do not continue to send the patient statements or dunning letters while the bankruptcy is being processed.

3. Account balances that become part of litigation can be particularly difficult to collect in a timely manner. Patients are unlikely to want to pay on these claims until the case is settled. A letter of protection or lien may be obtained from the patient's attorney. Continue to follow up with the attorney monthly.

4. A caveat may be filed in your county probate court for patient balances that remain after you have been notified that the patient is deceased. Both the business office coordinator and the administrator should approve this action before it is taken. A form for your state may be obtained from the State Probate Office. If the caveat is returned stating that estate benefits have been exhausted, the account should be written off to bad debt.

I. ***Collection Agency Referrals***

1. Before an account is put on the collection agency list, which must be reviewed and approved by both the business office coordinator and Center administrator, the following should occur:
   a. Statements should have been sent at least monthly;

b. Two telephone contact attempts should have been made and documented;
c. Three dunning letters, including a final notice that the account will be placed with a collection agency in ten days if payment is not received.
d. Discovery that a patient gave false information, has moved with no forwarding address and cannot be contacted through employment or relatives, has written checks on a closed account, has not repaid an NSF check within 10 days, or has kept a payment made by the insurance company are all items that may trigger referral to a collection agency.
e. Collection agency accounts should continue to be monitored every 30 days until it collected or it is evident that further collection attempts would be unsuccessful.

2. Sufficient information (patient ledger, tickler note entries, copies of all letters should be provided to the collection agency.

3. Once an account is forwarded to a collection agency, all communication from the procedure center/billing office must stop. This includes any written communications as well as telephone contacts.

4. If a payment is received on a collection agency account:
   a. Do a correction of write-off for the full amount that the patient paid to the agency.
   b. Correction is labeled “collection payment received”.
   c. Apply payment equal to the actual money sent to the center from the agency (patient payment minus agency commission). Payment is labeled “payment from collections”.
   d. Apply write-off equal to commission withheld by agency. Label write-off “collections expense”.
   e. Account should equal zero again.

5. Uncollectible accounts for balances under $10 should be written off to bad debt and should not be placed with a collection agency.

AdventHealth Surgery Center Ormond Beach AdventHealth Surgery Center Port Orange		
SUBJECT: PATIENT FINANCIAL COUNSELING Page 1 of 2		
POLICY: BO-22	**EFFECTIVE DATE:**	**DATE REVISED: 7-2023**

PURPOSE
To describe parameters for appropriate, adequate and timely patient financial counseling.

POLICY

A. The Center completes financial counseling for all patients scheduled for a procedure at the Center that will have a financial payment responsibility.

B. Upon completion of insurance verification, the insurance verifier will forward information regarding deductibles, co-pays, self-pays, etc. to the patient financial counselor.

C. The patient financial counselor will contact the patient (or responsible party if the patient is a minor) at least three days but preferably one week prior to the date of procedure to inform the patient of his/her financial responsibility and respond to any and all questions regarding the patient's insurance coverage as determined during insurance verification for the scheduled procedure.

D. Co-pays and deductibles are due on the day of procedure.

E. Payment in full should be requested from the patient on the date of service. Payment can be made by cashier's check, credit card, money order, or cash.

F. Self-pay patients are expected to pay in full by the date of procedure.

G. If the patient refuses or cannot afford full payment on the date of service, a promissory note must be signed and the following payment plans may be offered, listed in the order of preference.

1. 50% at admission and payment of the remaining 50% in three (3) equal monthly payments.
2. 50% at admission, payment of the remaining 50% in six (6) equal monthly payments.
3. 50% at admission, payment of the remaining 50% in twelve (12) equal monthly payments.
4. Any promissory note extended over the twelve months will need prior approval by the Administrator and Executive Director..

H. Any other payment arrangements must be made with the written approval of the Administrator and Executive Director. No patient should be denied care without approval of the administrator or designee.

I. For services not covered by Medicare, the patient must be made aware of their responsibility and sign a properly completed Advanced Beneficiary Notice (ABN) or Notice of Exclusion of Medicare Benefits (NEMB). *(See Financial Policy - Medicare).*

PROCEDURE

A. Contact the patient at least three days prior to procedure.

B. Be aware of any unusual circumstances that may require additional information from the patient, e.g. second opinion, proof of full-time student status, etc.

C. If the patient states that he/she cannot pay the deductible amount due, even after being offered credit card payment, negotiate a promissory note with the patient based on guidelines on #G above. ***Please note that a recurring credit card payment may also be accepted for promissory note terms. If the patient selects this method of making monthly payments, complete both the appropriate promissory note and recurring credit card payment form.*** If the patient cannot meet this level payment, advise him/her that you will call back after speaking with a manager.

D. If the patient claims inability to make payment of any kind, refer the account to the Administrator and Executive Director to determine if Charitable Consideration will apply.

E. Upon the patient's arrival on the date of service, the patient should complete all necessary paperwork, offer his/her insurance card and identification for copying, sign the promissory note, remit the agreed upon payment, and receive a receipt for any payment.

F. The patient should receive a copy of any consent forms, release of information forms, and assignment of benefits forms they sign, as well as a copy of the promissory note, if applicable. They should also receive instruction as to whom to contact if they have further questions about their insurance or payments due.

G. A copy of the promissory note, insurance card (front and back), and patient's identification must be forwarded to the billing staff member. *If insurance cards are scanned into software, it is not necessary to forward copies to the billing staff member.*

☐ **AdventHealth Surgery Center Ormond Beach**

☐ **AdventHealth Surgery Center Port Orange**

FINANCIAL DISCLOSURES

The State of Florida requires that we provide the patients of our Centers the following disclosures:

A. ***Services may be provided in this health care Center by the facility as well as by other health care providers who may separately bill the patient and who may or may not participate with the same health insurers or health maintenance organizations as the facility.***

B. **You may pay less for this procedure or service at another facility or in another health care setting.**

C. **Services may be provided in this health care facility by the facility as well as by other health care providers that may separately bill you. You will be separately billed for the following:**
   - **Surgeon fees**
   - **Anesthesia services fees**
   - **Pathology fees if any biopsies were taken**

D. **You should contact your insurer or health maintenance organization regarding your cost-sharing responsibilities**

E. **The State of Florida's regulatory agency has a pricing website that provides information on payments made to the facilities for defined service bundles and procedures. The website is located at: http://pricing.floridahealthfinder.gov**

F. **This service bundle information is a non-personalized estimate of costs that may be incurred by the patient for anticipated services and that actual costs will be based on services actually provided to the patient.**

G. **Patients and prospective patients may request from this facility and other health care providers a more personalized estimate of charges and other information. Patients and prospective patients should contact each health care practitioner who will provide services in the ASC to determine the health insurers and health maintenance organizations with which the health care practitioner participates as a network provider or preferred provider.**

H. **For further information on financial policies, please go to the following Center's website or contact the Center's billing liaison for:**

   AdventHealth Surgery Center Ormond Beach at (386)-271-7105 or their website at AdventHealth Surgery Center Ormond Beach | AdventHealth Daytona Beach

   AdventHealth Surgery Center Port Orange at (386) 777-7151 or their website at- AdventHealth Surgery Center Port Orange | AdventHealth Daytona Beach | AdventHealth