Klickitat Valley Health			
Policy/Procedure Name:	Amounts Generally Billed (AGB)		
Department/Scope:	Patient Financial Services		
Most recent review/revision date:	1/1/2025	**Pages:**	2

Purpose and/or Policy Statement:
To define the procedure for determining the amounts generally billed

Definitions:
AGB - Amounts Generally Billed
FAP - Financial assistance policy

Procedure:

Amounts Generally Billed (AGB)

A hospital organization meets the requirements of Section 501(r)(5) with respect to a hospital facility it operates only if the hospital facility (and any substantially-related entity) limits the amount charged for any emergency or other medically necessary care it provides to a FAP-eligible individual to not more that the amount generally billed (AGB) to individuals who have insurance covering such care.

The amounts charged to FAP-eligible individuals for all other medical care covered under the FAP is limited to less than the gross charges for that care.

Medically Necessary Care

In defining medically necessary care for purposes of its FAP and the AGB limitation, a hospital facility may, but is not required to, use the Medicaid definition used in the hospital facility's state, other definitions provided by state law, or a definition that refers to the generally accepted standards of medicine in the community or an examining physician's determination.

AGB Calculation under the Prospective Method

A hospital facility using the prospective method may determine AGB for any emergency or other medically necessary care provided to a FAP-eligible individual by using the billing and coding process the hospital facility would use if the FAP-eligible individual were a Medicare fee-for-service or Medicaid beneficiary. The hospital facility would set the AGB for the care at the amount the hospital facility determines would be the total amount Medicare or Medicaid would allow for the care (including the amount that would be reimbursed by Medicare or Medicaid and the amount the beneficiary would be personally responsible for paying in the form of co-payments, co-insurance, and deductibles).

A hospital facility using the prospective method may base AGB on Medicare fee-for-service or Medicaid or both, provided that, if it uses both, its FAP must describe the circumstances under which it will use Medicare fee-for-service or Medicaid in determining AGB.

Gross Charges

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A hospital facility must charge a FAP-eligible individual less than the gross charges for any medical care covered under the hospital facility's FAP. However, a hospital facility may issue a billing statement to a FAP-eligible individual for medical care covered under the FAP to state the gross charges for such care and apply contractual allowances, discounts, or deductions to the gross charges, provided that the actual amount the individual is personally responsible for paying is less that the gross charges for such care.

Safe Harbor for Certain Charges in Excess of AGB

A hospital facility that charges a FAP-eligible individual more than AGB for emergency or other medically necessary care or gross charges for any other medical care will not fail to meet the requirements of Section 501(r)(4) if all of the following conditions are met.

- The charge in excess of AGB was not made or requested as a pre-condition of providing medically necessary care to the FAP-eligible individuals (for example, an upfront payment the hospital facility requires before providing medically necessary care).
- As of the time of the charge, the FAP-eligible individual has not submitted a complete FAP application to the hospital facility to obtain financial assistance for the care or has not otherwise been determined by the hospital facility to be FAP-eligible for the care.
- If the individual subsequently submits a complete FAP application and is determined to be FAP-eligible for the care, the hospital facility refunds any amount the individual has paid for the care (whether to the hospital facility or any other party to whom the hospital facility referred or sold the individual's debt for the care) that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than $5.

References:

IRS Section 501(r)(5)
https://www.irs.gov/charities-non-profits/limitation-on-charges-section-501r5