

Memorial Hospital  
Carthage, Illinois

POLICY TITLE: Financial and Collection Policy

RECOMMENDED BY: Revenue Cycle Teams

CONCURRENCE(S): Memorial Medical Clinics

REVIEWED: \_\_\_\_\_

ADMINISTRATIVE APPROVAL: \_\_\_\_\_

SUPERSEDES: Credit & Collection Policy

EFFECTIVE DATE: October 2006

REVISED: 01/09, 07/10, 08/11, 01/13, 12/15, 06/17, 10/18, 08/19, 03/20, 02/21, 03/22, 4/23, 7/23

MEDICAL STAFF/DIRECTOR APPROVAL: \_\_\_\_\_

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Standard:

The Hospital acts as a vehicle for the billing of services to a patient's third party carrier. It is the ultimate financial responsibility of the patient to make payment for services received within the guidelines of the Financial and Collection Policy.

Performed by: Revenue Cycle Teams.

Definitions: None needed.

Equipment: None needed.

#### NO SURPRISE BILLING ACT

The No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers.

Public notices on patient rights to good faith estimates and rights related to balance billing shall be prominently displayed in clear and understandable language. They shall be posted on the facility's website and in at least two prominent locations within the facility, particularly offices where patients commonly schedule services.

The No Surprises Act (NSA) requires providers to furnish good faith estimates (GFEs) to patients under a variety of scenarios. Currently, providers and facilities must furnish a GFE to uninsured or self-pay patients who schedule an item or service or request a GFE. Additionally, out-of-network providers or facilities may need to include a GFE when seeking to balance bill a patient in certain allowable situations.

Pre-cert staff will create an estimate for out of network scheduled testing. Patient Access staff then must inform the patient of their out of network or private pay status and present them with a good faith estimate prior to or at the time of service (timeframe outlined below). The patient must sign the estimate or choose to have services elsewhere.

Estimates (within \$400 accuracy) as well as consent are required to be provided to the patient and signed within a set timeframe (outlined below). Estimate letter templates have been created to satisfy the estimate and consent requirements of the NSBA.

## Non-Emergent Services- Out of Network Patient

<b>Service Scheduled</b>	<b>Deliver Notification and Estimate Before</b>	<b>Receiver Signed Form By</b>
72+ hours in advance	At least 72 hours before	At least 72 hours before services are to be provided
24-72 hours in advance	Same Day	At least 3 hours before services are to be provided
Less than 24 hours in advance	At least 3 hours before	A least 3 hours before services are to be provided

## Good Faith Self-Pay Estimate

<b>Service Scheduled</b>	<b>Deliver Notification and Estimate By</b>	<b>Receive Signed Form By</b>
72 hours in advance	At least 72 hours before	At least 72 hours before services are to be provided
Less than 72 hours in advance	N/A	N/A

### **PRE-REGISTRATION PROCEDURES:**

For emergency services, the Hospital will admit and render emergency medical services to patients regardless of their ability to pay.

Pre-registrations should be completed for all scheduled services whenever possible.

Insurance verification and pre-certification requirements:

For financial planning purposes, prior to and/or during the patient's stay/visit, the responsible party for payment and/or the third party coverage must be verified. Third Party Coverage verification includes effective date of medical coverage, deductible and co-pay amounts, coverage of admitting diagnosis, special billing requirements of third party, and pre-certification requirements for the patient admission.

Financial Counseling:

Financial Counseling should be conducted for all admissions on self pay portions where applicable.

For elective services and procedures that are not covered by a third party payer or if insurance coverage is not available, hospital patients are to pay in full or at a minimum a 50% deposit is desired.

Co-pays and deductibles identified at the time of service and/or at time of insurance verification are to be attempted to be collected prior to or at that time of service.

FINANCIAL ASSISTANCE: See Financial Assistance Policy.

DISCOUNTS: See Uninsured Patient and Prompt Pay Discount Policy.

#### THIRD PARTY PAYER BILLING PROCEDURES:

Patients on Medicare or a Medicare Part C Plan (Medicare Advantage): We will bill Medicare for our patients. When we receive payment, we will then bill any secondary insurance carrier for the balance. If payment is not made by the secondary carrier within 30 days, we will ask the patient to contact their insurance company to speed up payment. If there is no secondary insurance carrier, the balance will be due from the patient within 30 days.

Patients with Commercial Insurance: We will bill our patient's commercial insurance carrier. If we have not received payment from the insurance carrier within 30 days, we will ask the patient to contact their insurance company to speed up payment. (Note: If adequate information to bill has not been received, the account will be considered self pay.) As an additional service to our patients, we will assist our patients with completing prior authorization and pre-certification. However, patients are responsible for verifying the pre-certification process has been completed.

Patients with Public Assistance: We will bill Medicaid or any Medicaid replacement plan for our patients if a valid insurance card is presented at the time of service. Self-pay balances after Medicaid will be due within 30 days.

Patients with Employment Injuries: If our patient's employer has recognized their injury as work related, we will bill the employer and/or appropriate worker's compensation insurance company. If payment is not received within 30 days of the date billed, we ask the patient to notify their employer to speed up payment. If the claim is denied, we will bill the patient directly and payment is due within 30 days.

Patients with Injuries that are not Employment Related: If home owner's insurance, auto insurance, or a third party liability insurance is involved and adequate billing information is provided, we will bill the claim. If payment is not received within 30 days of the date billed, we will ask the patient to contact the insurance company to speed up payment. If insurance denies the claim, the patient is fully responsible and payment is due within 30 days.

Out of Network Providers: Patients may receive a separate bill for services with healthcare professionals affiliated with the hospital and some may not be participating providers in the same insurance plans and networks as the hospital.

If laboratory, radiology, cardiology or surgery services are performed, a separate bill from other professional offices may be received.

## PATIENT BILLING PROCEDURES:

Itemized bills: Itemized bills are available upon request.

Patients without insurance: Payment in full is expected within 30 days from the date of discharge.

Private pay patients: Once a patient is determined to be self-pay (no third party payer to bill), the account will be referred to a contracted professional medical billing company used by Memorial Hospital.

The contracted professional medical billing company will assist in the preparation of statements and the processing of payments for our self-pay patients and to provide our patients with payment options for their account balances according to the guidelines within this policy.

The billing company will work all accounts for a minimum of 120 days. As accounts fall outside of the guidelines, the billing company will prepare a listing of accounts that have gone through standard collection activity and submit to the Patient Account Lead or Director of Revenue Cycle to be reviewed for approval to forward to the Collection Agency.

Bad debt accounts will be worked by an independent contractor.

## PAYMENT ARRANGEMENTS:

The Hospital is a healthcare organization and not a lending institution. Every effort will be made to counsel the responsible party to utilize outstanding lending institutions. Available financing options should be used when applicable.

Memorial Hospital will agree to monthly payments on unpaid balances based on the Payment Plan Schedule listed below.

### Payment Plan Schedule:

A minimum monthly payment of \$25.00

Balances under \$200.00 – paid within four (4) months

Balances from \$201.00 through \$600.00 – paid within eight (8) months

Balances over \$600.00 – paid within twelve (12) months

No exceptions to this payment plan schedule are to be made without the approval of the Chief Financial Officer, Chief Executive Officer or the Director of Revenue Cycle.

If a patient lacks the funds to pay the hospital bill, it is the patient's responsibility along with guidance from Patient Accounts staff to apply for financial assistance, Medicaid, etc.

## PAYROLL DEDUCTION:

Payroll deduction is a method of payment offered to employees. Employees may sign up for payroll deduction for account balances at Memorial Hospital or any of the hospital owned clinics.

If an account has been referred to the collection agency, the Patient Account Lead, Director of Revenue Cycle and/or Chief Financial Officer have the authority to pull the account back from the agency for payroll deduction as long as the account has no current payment arrangement in place or not in legal status at the collection agency and the account is for a dependent or immediate family member of the employee.

CHARGING INTEREST: Memorial Hospital does not charge our patients interest.

CREDIT BALANCES:

Reconciliation and/or refunds will be processed within 60 days of the receipt on credit balance accounts.

Refunds of any overpayments made by the patient who is eligible for financial assistance over the patient portion will be processed if greater than \$9.99.

Patient Account staff will request refunds on patient accounts by completing a refund request form. Refunds over \$500 must have the approval of the Director of Revenue Cycle. Refund requests should be forwarded to Fiscal Services for processing.