CaroMont Regional Medical Center Administrative Policy		
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Credit & Collections Policy

POLICY

Patient Financial Services is responsible for accurate billing and prompt collection of charges for services provided by CaroMont Regional Medical Center and all other hospital departments.

PURPOSE

Patients are expected to pay applicable deductibles, co-pays, and/or co-insurance amounts prior to or at the time services are rendered. If payment cannot be made, patients may be required to provide financial information that will enable determination of payment sources and responsibilities, provision of credit, or reference for financial assistance programs.

Our goal is to maintain financial solvency of the organizations in order to continue providing exceptional healthcare services while being compliant with all regulatory requirements.

RESPONSIBILITY/SCOPE

Patient Financial Services, which consists of Access Management, Business Services, and Utilization Review is responsible for compliance of this policy.

PROCEDURE/GUIDELINES

PRE-SERVICES/INHOUSE SERVICES

PRE-REGISTRATION/REGISTRATION

Attempts are made to pre-register patients scheduled for defined procedures prior to the date of service. Patients not registered prior to service will be registered at the time of service. Patients also have the option of updating/verifying registration information prior to service on the MyChart patient portal.

INSURANCE VERIFICATION

Attempts to verify insurance benefits, obtain coverage levels, and initiate and/or obtain an authorization for inpatient and observation accounts as well as for those outpatient accounts registered prior to service. When insurance coverage information is obtained prior to service, the

organization will attempt to contact the patient to arrange for financial resolution of their account by taking payment over the phone, obtaining a promise to pay at the time of service, completing an application for the outside finance company/in-house finance option, or referring the patient to an available assistance program.

UNINSURED FINANCIAL CLEARANCE

Uninsured patients will be required to make acceptable financial arrangements prior to being scheduled for non-emergent services. If patients are unable to make acceptable financial arrangements, the financial counselor will notify the physician's clinic by telephone and refer the patient back to the physician's clinic. The physician's clinic then has the option to determine other treatment options or make a formal Request for Reconsideration of the decision.

COSMETIC PROCEDURES

Cosmetic procedures are required to be paid in full prior to the service being provided. Since discounts are already considered in the charge, Prompt Pay and Uninsured Financial Assistance Discounts do not apply.

HEALTH INSURANCE BILLING

COMMERCIAL/MANAGED CARE INSURANCE

We participate in most major managed care plans and will file a health claim for patients who provide all of the required commercial/managed care insurance information and assign benefits to CaroMont Health.

If commercial/managed care insurance information is not provided by patient, responsible party or payer until after admission or service date, the patient will be billed if services are denied due to delayed notification or non-coverage.

Co-pays, deductibles, co-insurance, and fees for non-covered services are due at the time of service.

MEDICARE/MEDICAID

Our entities and providers enrolled in Medicare and Medicaid and will file a health claim for patients covered under these programs.

Medicare inpatient deductibles and Medicare co-pays are due at the time of service unless other acceptable financial arrangements have been made.

Medical Necessity

We will not refuse services for patients with medically necessary orders that fail to meet Medicare's local review policies. For those potentially non-covered services, patients may be financially responsible for the cost of the service.

Self Administered Drugs

The Medicare program does not pay for self-administered drugs prescribed to OUTPATIENTS. We will bill Medicare outpatients for oral or self-administered drugs, which will be the financial responsibility of the patient.

Liability Coverage When Medicare Or Medicaid Is Secondary

We will seek and file liability coverage in accordance with Medicare Secondary Payer (MSP) guidelines. Medical liens will be filed on these claims to protect the interest of the organization. We choose not to wait for a liability settlement, Medicare and/or Medicaid will be billed 120 days (or later) from the date of service. These procedures are in compliance with all government rules and regulations related to liability coverage. We may choose to hold Medicare billing when it appears that a settlement may be imminent.

LIABILITY

Claims are filed to liability insurance carriers and/or attorneys that represent the patient. Medical liens will be filed on these claims to protect the interest of the organization. Patients are encouraged to also file their private medical insurance to ensure that all authorizations and billing timelines are met since liability has no guarantee of payment. The patient and/or guarantor will remain liable for all charges.

WORKERS COMPENSATION

Workers' Compensation claims will be filed after the workers compensation payer information is provided and the coverage is verified through the patient's employer. If denied, we will seek to file a claim with the patient's primary insurance carrier or the patient.

HEALTH INSURANCE FOLLOW-UP

We will assist patients with third party claim follow-up as needed in order to obtain prompt payment or resolution. We may employ the use of outsource vendors to assist with follow-up of denied, unpaid, or underpaid claims.

INSURANCE APPEALS

Utilization Review, Clinical Documentation Improvement, and/or Business Services staff make insurance appeals to the payers.

Appeals concerning the patient's balance after the insurance processes will be the responsibility of the patients/insured parties.

PATIENT FINANCIAL RESPONSIBILITIES

Patients who do not carry insurance coverage, are unable to provide adequate information to file health insurance, or who wish to file their own insurance claims must either make payment in full or make other satisfactory financial resolution at the time of service.

Patients are responsible for paying applicable deductibles, co-pays, co-insurances, or other amounts not covered by insurance when services are rendered. These requests for payments are ESTIMATED amounts due and are not considered the final balance due.

Insurance claims are submitted as a courtesy to our patients. Pending or delayed insurance payments do not relieve patients of their financial obligation. Any balance due after the insurance pays their portion will be sent to the patient on a billing statement.

NO SURPRISE MEDICAL BILLS

Emergency care is covered by insurance plans with in-network patient benefits applying when services are received at any out of network hospital.

GOOD FAITH ESTIMATES

Scheduled Uninsured patients receiving non-emergent services will receive a good faith estimate prior to service. This includes related costs from other providers.

UNINSURED FINANCIAL ASSISTANCE DISCOUNT

An uninsured discount is applied to all uninsured patient accounts at the time the bill drops and before a statement is produced. The uninsured discount ensures uninsured patients are billed the same amounts generally billed to insured patients for emergent or other medically necessary services.

PROMPT PAY DISCOUNTS

Prompt pay discounts may be offered to uninsured patients who pay their bill under the terms and time frame of the Prompt Pay Discount Procedure. Cosmetic procedures are not subject to the Prompt Pay Discount. The Prompt Pay Discount is in addition to the Uninsured Discount.

PATIENT PAYMENT OPTIONS

We realize that many services provided result in unexpected expenses to our patients. Therefore, we offer many payment options that can be made via telephone, electronically, mail, on-line at CaroMontHealth.org or MyChart patient portal:

- Cash
- Check/Money Order
- Debit Cards
- Credit Cards: Visa, MasterCard, Discover, American Express
- Medical Flex Card
- Short Term Payment Plan
- Long Term Payment Plans
- Employee Payroll Deduction
- Employee PTO Payout

EMPLOYEE PAYROLL DEDUCTION

CaroMont Health recognizes the valuable resource in its employees. All active employees maintaining a regular schedule are eligible for payroll deduction.

Staff in Patient Financial Services will use the "Payroll Deduction Policy" guidelines in order to determine the amount of payments necessary to satisfy the total balance due within the maximum allowed pay periods.

The employee is responsible to initiate and sign the authorization for payroll deduction, and must contact Patient Financial Services to add new accounts to existing balances. Employee payroll deduction may apply to any accounts for which the employee is financially responsible.

Upon employment termination, all past due balances will be collected as part of the final paycheck if funds are available.

In absence of satisfactory arrangements, the account shall be processed the same as those for non-employees.

FINANCIAL/CREDIT APPLICATION

Patients not able to satisfy their financial obligations from the aforementioned options will fill out a Financial/Credit Application (Appendix A). This information and/or information obtained from a Credit Reporting Agency will be used to determine bank financing terms and possible eligibility for any financial assistance programs.

FINANCING/PAYMENT PLANS

Short Term Payment Plan

- Six and twelve month payment plans same as cash with no interest
- Minimum monthly payment $25.00

Long Term Payment Plans

- Three year payment plans with low or no interest
- Five year payment plans with low interest

GOVERNMENT ASSISTANCE

We have trained staff that offer assistance in determining eligibility and applying for Government Assistance Programs based on financial need and other circumstances. Patients must provide required documentation in order to qualify for assistance.

FINANCIAL ASSISTANCE

Medically necessary services are offered free of charge or at a reduced patient responsibility through our Financial Assistance Program. North Carolina residents may qualify when services are deemed medically necessary. Determination of qualification for financial assistance will be based on the patient's income and family size.

Emergency Department visits for both insured and uninsured patients will be subject to a $35.00 patient cost share but, not to exceed the cost sharing under the patient's health plan, even when approved for 100% Financial Assistance.

Potential eligibility exists only after reimbursement efforts from all other third-party resources, federal, state, and local assistance programs have been exhausted.

HEALTHNET GASTON

HealthNet Gaston is a joint venture between CaroMont Health and other community organizations. This program assists uninsured patients that meet established financial and clinical criteria by referring the patient to participating primary care and/or specialty physicians for continuance of care at no cost. HealthNet Gaston patients will be required to complete a Patient Financial Services screening prior to services being scheduled. Final determination for approved scheduled services will be determined after the Patient Financial Services screening.

A $35.00 cost share for HealthNet Gaston patients seen in the Emergency Department will apply the same as all other patients that qualify for Financial Assistance.

PATIENT COLLECTIONS

Communication letters are mailed to patients when third party coverage is pending or denied. After the third party payment is received and to the extent permitted by law, any additional remaining balance will be billed to the patient and due upon receipt of the statement. If the entire balance is not paid by the due date, it is the patient responsibility to make acceptable financial arrangements.

Delayed insurance payments do not relieve patients of their obligation to pay balances when due; the responsibility still rests with them.

BAD DEBT

While we strive to collect money owed on outstanding patient accounts, those deemed uncollectible by Patient Financial Services will be written-off to bad debt status. At that time, the accounts will be placed for collection with a collection agency.

Collection Agency Placement

Patient accounts deemed uncollectible may be placed with an outside collection agency to attempt further recovery efforts. After placement is made with an outside agency, appropriate measures are followed to again notify the patient of the debt and allow time for dispute.

Deceased Patients

The estate or any party responsible for the account balance of a deceased patient (for example, spouse, parent of a minor, etc.) will be billed. When no estate or responsible party exists, the account may qualify for Financial Assistance approval.

Bankruptcy

Patient collection activities, including billing statements, letters, and phone calls will discontinue upon receipt of bankruptcy notification. If the account was assigned with a collection agency prior to receipt of notification, it will be closed and returned.

Claims for Chapter 11 (business) and Chapter 13 (individual) repayment programs will be filed as appropriate.

CREDIT BALANCES

We are committed to promptly refunding the proper party when a credit exists on a patient account as follows:

- Medicare and Medicaid Credit Balance Reports are submitted quarterly based on the established governmental guidelines.
- Overpayments made by the patient or private payer that appear on any given account may be used to satisfy other outstanding accounts before a refund would be issued.
- Overpayments made by commercial/managed care payers are repaid when discovered during review or when appropriately requested by the commercial/managed care payer.

EXTENUATING CIRCUMSTANCES

In extenuating circumstances, some contents of this policy may be waived if deemed in the best interest of the organization and/or patient.

DEFINITIONS

Financial Assistance – services that are provided to indigent patients at no cost or a reduced rate based on income and family size
Bad Debt – patient account balances deemed uncollectible by Patient Financial Services.

Amount Generally Billed (AGB) - amounts generally billed for emergent or other medically necessary care to patients who have insurance for such care.

Scheduled Services - medical care that is scheduled prior to anticipated delivery of care. It is expected that patients in this category will receive financial screening and counseling prior to the service being provided.

Unscheduled Services - medical care that is emergent and/or urgent in nature. Financial screening prior to admission or service is not possible in these instances; however, depending on the circumstances and to the extent permitted by law, follow-up financial counseling is expected at registration, during the patient stay, or at discharge