Reedsburg AREA MEDICAL CENTER
Organization Focused

PATIENT FINANCIAL AND BILLING GUIDELINES POLICY

Effective date: August 15, 2021

PURPOSE: To maintain quality health care through appropriate billing and collection practices, thereby reducing Accounts Receivable and maintaining good public relations.

LEVEL: Independent

SUPPORTIVE DATA:

- This facility follows credit and collection procedures in accordance with regulations outlined in the U.S. Fair Debt Practices (Public Law 95-109).
- All billing inquires shall be handled by medical center personnel in a timely manner. Any billing concerns or complaints that cannot be resolved by Patient Accounts/Business Services staff shall be referred to Administration for further review. At all times during this process, the patient's right to non-harassment and confidentiality shall be protected.
- Billing shall be handled in the same manner respectively to its type and payer. (For example, all Medicare bills shall be handled according to Medicare guidelines; all HMO bills shall be handled according to HMO contract guidelines, etc.).
- **Refer to Organization Focused Manual:**
  - Authorization for Disclosure of Billing Information—(LD)
  - Community Care and Financial Assistance Policy—(LD)
  - Eligibility Notification for Community Care—(LD)
  - Registration-Financial Clearance Guidelines

CONTENT:

Professional Courtesy

- Professional courtesy outside of intra-practice is prohibited. Example of exception: Physician within same group to another physician within same group is accepted.

Waivers and Insurance-Only Billing

- Waivers and insurance-only billing is prohibited. Waivers are routine adjustments to copays, coinsurance and deductibles in the absence of financial hardship. Insurance-only is accepting the amount the insurance paid as payment in full on a routine basis.

Insurance Filing Deadline

- . The hospital will file the claim and once the insurance company denies because of missed deadline, hospital billers shall file an appeal with the necessary information to prove lack of patient accountability. If the appeal is denied, the hospital can bill the patient for the balance due.

RAMC Employees

- Effective 1/1/17, employee discounts are no longer offered.

Financial Arrangements

- Discounts for self-pay/uninsured accounts that do not qualify for financial assistance are as follows:
  a. Contractual discounts take precedence over discounts noted in this protocol. Exceptions may occur on an individual basis at the discretion of the Director of Revenue Cycle..
  b. An automatic discount of 25% will be noted on the initial billing for the uninsured patients.

- Services Exempt from Discounts:
  - Private Pay Swing Bed (exception: Ridgeview Heights residents)
  - Cardiac Rehab Phase III
  - Hearing aids and related supplies
  - Complementary Health Services (e.g. massage therapy, etc.)
  - Cosmetic Procedures
  - Bariatric services, Industry services through Occupational Medicine clinic
  - Other services and supplies identified from time to time by medical center
- Payment Plans/Arrangements:

- Patients unable to pay their outstanding balances after application of all appropriate discounts have been applied, are eligible for 2 payment plan options:
    1. Short term arrangements:
        - Balance due < $100 pay in 1 month
        - Balances between $101 – 250 pay in 3 months
        - All other balances pay in NO MORE than 6 months
        - Initial payment for plan required at the time patient establishes the payment plan
    2. Long Term Arrangements:
        - For Balances between $500 and $8000 only
        - Application for outside vendor zero interest line of credit required.
    3. Balances greater than $8000, or patients who do not qualify for long term arrangements and Community Care:
        - Need review by Director of Revenue Cycle and CFO for payment determination.

a. Patients with at least 5 accounts assigned to a collection agency (bad debt), with a total outstanding liability of at least $600 are required to pay any estimated patient liabilities prior to their service date, or may have their appointments canceled.
b. Patient with at least 15 accounts assigned to a collection agency (bad debt) with a total outstanding liability of at least $5000 may have the patient privileges at RAMC and its affiliated physician groups revoked according to the PATIENT TERMINATION policy.

Billing & Collection

- Patients shall receive a summary of the hospital bill or an itemization including service dates upon request if/when charging and medical record information is complete. This summary is based on itemized charges on file in the RAMC billing system. Collection department staff shall document in the computerized notes the date of the request and the date the itemized statement was sent. **Exceptions:**
    a. Medical Assistance recipients: Effective 2/21/14:
    Forward Health changed their policy regarding a records request from a member or authorized person acting on behalf of the member. When a member or authorized person acting on behalf of the member requests the member's billing information or medical claim records, a provider is required to do the following:
        1. Send a copy of the requested billing information or medical claim records to the requestor.
        2. Send a letter containing the following information to Forward Health: Member's name, Member's Forward Health ID number or SS#, if available, member's date of birth, date of service, entity requesting the records, including name, address and telephone number.
        3. The letter must be sent to the following address:
        WI Casualty Recovery – HMS
        STE 100
        5615 Highpoint Dr.
        Irving, TX 75038-9984

        Note: This does not include billing record requests to attorneys, insurance companies, or other entities.

Non-payment by Insurance:

- If no response after filing insurance, the account will auto-reject after 45 days for non-contracted and third party insurances (excluding Workers' Compensation claims). The first cycle statement is sent to the patient automatically with a message indicating same.

Balance Due by patient:

- Guarantor Dunning statements begin the day after self-pay balance determination, and process every thirty (30) days until account resolution or assignment to bad debt collection agency.
- Collection letters will be sent through billing system on cycles in conjunction with guarantor statements, with final notice letter going out 90 days after initial balance determination.
- If no response after 30 days of final notice, account is reviewed by the Patient Accounts staff and the Director of Business Services and then referred to the collection agency.

- Active account balances of $9.99 and $-9.99 are adjusted off each month as a small balance adjustment unless the patient has another open account to which a credit balance should be applied.
- Effective 6/1/15, late charges under $100.00 will not be re-billed to the insurance company.

Refunds

- When insurance companies have not responded to review and recall or written correspondence within contracted billing limits, the patient will be refunded the balance. If the insurance company responds later than the contracted billing limits, the insurance company will be directed to request the balance from the patient. Medicare and Medical Assistance overpayments will be refunded within 60 days of discovery of overpayment.

Negotiated Discounts

- When extenuating conditions allow for negotiation of charges/discounts by department directors/administration, the recommendation shall be approved by the Director of Revenue Cycle.

Collection Referrals

- Collection attempts must be completed. Each account to be referred is reviewed by the Patient Accounts staff and approved by the Director of Revenue Cycle.

Community Care

- See Community Care Policy.

Returned Checks

- Returned checks due to non-sufficient funds shall incur a $20.00 processing fee.

REFERENCES:

1. Wisconsin Medical Assistance Provider handbook
2. WHA Billing and Collection Guidelines for WI Hospitals