Reedsburg
AREA MEDICAL CENTER
Revenue Cycle
Focused

REGISTRATION-FINANCIAL CLEARANCE GUIDELINES

Effective date: September 21, 2021

PURPOSE: To maintain quality health care through appropriate registration processes and financial clearance 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 inquiries 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.
- **Refer to Revenue Cycle Focused Manual:**
  - Authorization for Disclosure of Billing Information
  - Community Care and Financial Assistance Policy—(LD)
  - Eligibility Notification for Community Care---(LD)
  - Patient Financial and Billing Guidelines

CONTENT:

Commercial Insurance

- To enable accurate billing and payment reimbursement, registration shall request from the patient the appropriate insurance information at the time of registration.

Medical Assistance

- Patients who are public assistance recipients will have current identification card requested by registration at the time of service.

Accident Case (Liability)

- Patients admitted as a result of an accident shall be registered with their private health insurance. The hospital is not party to the accident and consequential settlement except for Medicare patients. Medicare requires providers to bill third party liability as primary payer whenever applicable. Medicaid accounts will be reviewed on a case by case basis to determine if we will bill the third party liability.

Worker's Compensation

- Insurance biller shall contact employers regarding services as deemed necessary. If the hospital cannot verify coverage, charges will either be billed to the patient's health insurance or designated private pay.

Law Enforcement

- Requests from Law Enforcement for medical clearance in the Emergency Department will be billed to patient's insurance or private pay.

Contracted Managed Care Insurance

- Patients with an HMO or PPO insurance coverage will be requested by registration to present their card at the time of service. All HMO and PPO admissions shall be reported to the appropriate insurance. Staff will use best practice efforts to collect applicable copays at the time of registration on date of service.

Self-Pay Accounts

- Any balances are due and payable within 30 days of discharge unless Patient Accounts has set up alternative pay arrangements with the patient. Financial Counselors will attempt to visit patient within 3 days of inpatient admission, and

when applicable offer information on Medical Assistance, Community Care, Financial Assistance Program, etc. This assistance shall be documented in patient account notes.

Insurance Filing Deadline

- Registration staff shall make every attempt to obtain correct insurance information from the patient and document those attempts. When patients fail to provide correct information in a timely manner, this may affect the hospital's ability to meet filing deadline requirements, potentially making the account balance completely patient liability.

Financial Arrangements

- Financial Clearance staff shall review third party coverage on all inpatient admissions and any prioritized outpatient services. On any elective non-emergency service, if financial arrangements cannot be verified, admission may be canceled or rescheduled after discussing the situation with the attending practitioner or surgeon prior to admission.
- RAMC requires a prior authorization for selected medications, procedures, and services. The prior authorization process is leveraged to verify member eligibility and facilitate the appropriate use of elective and/or non-urgent services.
- Authorizations should be requested **at least** 14 days prior to the date of service/admission to allow RAMC time to determine eligibility, level of benefits, medical necessity and to collect any patient liability. 21 days prior is preferred.
- Failure to comply with authorization requirements may result in an administrative denial of the claim payment with the provider held liable for any denied claim.
- Payers' prior-authorization requirements for procedures and services are subject to change. For up to date information, refer to payer portals or contact insurers by phone.
- Patients may not be held liable for claims denied due to lack of the provider obtaining a prior authorization. Referring providers are responsible for allowing the RAMC financial clearance team enough time and appropriate documentation to support and obtain prior authorization for requested services.

The following information is required to submit an authorization request.

- Member's name
- PCP name and National Provider Identifier (NPI)
- Admitting Provider's name and NPI
- Facility's name, location and NPI
- Diagnosis and clinical information (as required by payers)
- Service requested
- CPT codes
- Admission date (if applicable)

Prior authorizations may be submitted electronically, by fax or over the phone. Authorizations' responses and confirmation numbers must be documented in patients' financial chart.

- After RAMC staff receive the prior authorization from the payer, appropriate staff will run patient liability estimates through the system.
- Staff will then attempt to call the patient to discuss the estimated liability, any other outstanding balances, and what payments arrangements are required to resolve all liabilities.
- Staff must document the attempts and any conversations with the patients in the patient financial record.

- When necessary, financial arrangements for payment are discussed with patient/guarantor during stay. Attending practitioner may be kept informed of patient's financial situation when applicable.
- The patient's financial situation is reviewed, when appropriate, to see if patient qualifies for Medical Assistance or Community Care. (Social Services may assist in this process.)
- Suggested collections for Uninsured, under-insured or Self-Pay accounts that do not qualify for financial assistance are as follows:
    a. Elective/non-emergency admissions and procedures - 50% of estimated charges upon admission, with flexibility based on patient financial status and cost of procedure. This will be documented in patient account notes.
    b. Clinic Office visits – Uninsured patients will be requested to pay a $150 deposit prior to, or at the time of, their visit.
        - If the patient decides they cannot pay on service date and request financial assistance counseling, the patient will be directed to Financial Clearance staff prior to their appointment.
        - These requirements will be waived if visit is included in global fee – based on direction from appointment schedulers.
    c. 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.
    d. 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.

RAMC Physicians Group OB Services: Insurance benefits for maternity coverage, for both Physician and Hospital services, will be reviewed to determine coverage and if down-payments will be required based on benefits.

- Applicable copays are due at time of office visits.
- Patients with deductibles and coinsurance will be asked to make arrangements to pay the estimated liabilities prior to the delivery date.
- Patients without health insurance coverage will be required to receive a financial review, and to make payment arrangements prior to the onset of services. .
- Payment arrangements balance not collected at the time of admission/service by Patient Financial Services for hospital, Physician Group Clinic and Specialty Group Clinic services, must adhere to the payment plan outlined in the Patient Financial and Billing Guidelines.. Staff shall use Community Care and payment plan options referenced in this policy to resolve any outstanding balances, keeping in mind the dual goals of continued positive patient relations and timely payment of the bill. Documentation of these discussions shall be made in the patient account notes.

1)