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| **Billing and Collections Policy** | | |
| **Effective Date: 01/20/2022** | **Original Date: 10/12/2021** | **Approval Date: 01/20/2022** |
| **Department(s) (Scope): Business Office** | | **Version**: **2** |

**Policy Statement**

Big Sandy Medical Center (BSMC) will efficiently manage the facility’s accounts receivable and provide a process of timely collection of accounts due to BSMC.

**Purpose**

It is the purpose of BSMC to provide quality care for the community of Big Sandy and the surrounding area. The maintenance of this non-profit medical center can best be attained within the framework of sound fiscal management. The following policy states the basic requirements of BSMC’s credit and collection effort.

All patients possessing orders from a staff physician will be admitted regardless of their ability to pay. BSMC will provide, without discrimination, care for emergency medical conditions within the meaning of the Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act to individuals regardless of their eligibility under the medical center’s Financial Assistance Program(s).

**Procedure**

1. **Registration**

In order for the system to generate a billing statement, patients will be registered and an account created in Evident. Charges and diagnoses will be entered on patient’s account(s) in a timely manner by the BSMC billing staff or their designee.

1. **Insurance**

BSMC will submit bills to all insurance carriers on behalf of the guarantor. It is the guarantor’s responsibility to provide BSMC with the necessary insurance information. If the guarantor is unable to provide the necessary information, the account will be entered into the system as self-pay.

Patients must present proper insurance cards at time of service. It is also the responsibility of the patient to inform the business office of any changes to coverage. The patient is responsible for all charges, regardless of insurance coverage. The filing of claims with insurance companies in no way relieves the patient from his or her obligation. Insurance benefits will be assigned to Big Sandy Medical Center at the time of treatment. Policy co-pays, deductibles, and/or co-insurance will be paid at the time of service.

**Medicare**

Patients must present proper Medicare identification and supplemental insurance cards at time of service. Claims will be submitted to supplemental insurance after Medicare payment has been received. The patient is responsible for items listed and informed of at time of service as non-covered under Medicare contract and deductible and/or co-insurance not covered by supplemental insurance.

**Medicaid**

Patients are required to present current Medicaid identification card at the time of service. If the patient has other insurance coverage, Medicaid will be billed as a supplemental insurance. Remaining balance, including cost share and non-covered services, is the patient’ responsibility

**Veterans Administration (VA)**

VA patients must have prior authorization from the VA for all hospital services. VA has defined some emergencies which are excluded from the prior authorization requirement. Authorization for services is both the patient’s and facility’s responsibility.

**Auto Accidents & Workers Compensation**

Most health insurance companies now exclude payment for any benefits which might be covered by auto insurance, worker’s compensation, or any other liability coverage. If any injury is the result of an auto, work place, or other accident where other liability coverage might exist, please notify the Business Office of BSMC at the time of treatment so that the appropriate billing action can be taken. The patient is responsible for the bill even if there may be a potential liability action.

1. **Prior Authorization**

Patients with requirements from the insurance carrier for prior authorization are required to contact their insurance carrier and to advise the BSMC Business Office at time of service.

If the patient fails to notify BSMC of their prior authorization requirements, any increases in deductible/co-insurance from the insurance carrier will be the patient’s responsibility. Any remaining balance from inpatient services is patient’s responsibility.

1. **Uninsured**

For those unable to pay cash at the time of discharge, payment arrangements must be made with the Business Office. Charges incurred by patients without insurance coverage will be due based on an agreed-upon payment schedule.

1. **Financial Assistance**

Financial assistance policy and application will be available to patients upon request.

If you are unable to pay your account in full, please contact the Patient Account Representative in the Business Office to set up a payment plan.

As part of the Inpatient admissions process, a representative from the BSMC billing staff will visit with all Inpatients and/or their financial representatives to determine insurance coverage. For patients in Observation or Inpatients that have insurance other than Medicare or Medicaid, a billing representative will call the insurance company to verify coverage and to determine if the stay requires prior authorization for payment. For all Emergency Room patients, insurance information will be obtained before the patient is discharged from the facility. For all Clinic Medicaid patients, patient eligibility and passport information are reviewed prior to the patient being seen.

Each business day, an electronic file of unbilled claims will be uploaded to the claim’s clearinghouse. Claims are forwarded to the appropriate payer electronically or printed to paper and mailed to the carrier by the clearinghouse. Workers’ Compensation claims are billed hard copy with copies of the corresponding medical record. Secondary insurance claims that do not automatically transmit from the primary insurance are billed hard copy with a copy of the Explanation of Benefits from the primary insurance carrier.

Once a payment or denial notice is received from the insurance carrier, the remaining balance will be billed to the secondary insurance or, if there is none, will be converted to a self-pay balance.

BSMC has the following options for patients once their self-pay balance is determined:

* + Assistance with applications for State of Montana financial assistance programs (i.e. Medicaid, HMK, etc.)
  + Assistance completing the application for BSMC’s Patient Financial Assistance Program
  + A 20% self-pay, prompt pay discount on all self-pay balances within 30 days of determining the self-pay balance
  + A short-term payment agreement with BSMC where the account balance from the first statement is divided into equal payments according to the timeline listed below:
    - 3 months $5.00-$500.00
    - 6 months $501.00-$1,000.00
    - 9 months $1,001.00-$2,000.00
    - 12 months $2,001.00+

The facility sends out billing statements for all self-pay accounts (which includes insurance co-pays and deductibles) monthly to the guarantor listed on the account. Detailed bills of accounts are provided to anyone upon request. Payments may be made to the facility by cash, money order, check or credit card.

Long Term Care accounts will be billed manually at the beginning of each month and are not eligible for alternative payment options or assistance.

Self-pay accounts that have received at least three statements and have not been paid in full or a payment plan established will be sent to third-party collection agency.

1. **Collection Process**
   1. In-house contact will be established with each patient/guarantor, usually at time of service, to ensure a complete file of payer information is available and, thus, ensure prompt payment.
   2. Telephone and written contact will be attempted with a patient/guarantor regarding a past due account. All calls must comply with current federal and state regulations regarding collection practices. An account is considered past due when no payment has been received 30 days after the initial statement is mailed out or if installment payments on the account have not been received for 30 days.
   3. A pre-collection letter will be sent on all delinquent accounts at least 15 days prior to being turned over to a collection agency. An account is considered delinquent when no payment has been received for 90 days after the initial statement is mailed out or when installment payments have not been received for 90 days.
   4. Bad debts will be listed with an appropriate collection agency when approved by the Director of Finance and/or CEO. An account is considered in default once it is turned over to the agency.
      1. Accounts that are sent to a collection agency for non-payment may be subject to interest charges.
   5. Collection agencies will be monitored on an annual basis.
   6. When approved by the CEO, legal action will be initiated by BSMC as necessary to collect receivables or to recover bad debts.

All accounts forwarded to a third-party collection agency will be written off as Bad Debt with BSMC.

1. **Itemized Statements**

Attorney’s, Insurance Representatives, and Insurance Claims Adjustors may be provided with an itemized statement when the request is accompanied by a written authorization, which has been signed by the patient/account guarantor and whose date is within 60 days of the request date.

1. **Filing of Creditor’s Claims and Estates**

A claim will be filed by the Director of Finance and/or CEO against estates upon receipt of a Notice to Creditors. Such notices are normally obtained from a newspaper clipping. The following steps are to be taken in each case:

* 1. Complete a Proof of Claim form by entering data pertinent to the estate in question. The patient’s accounts should be listed to show estate as guarantor (e.g. Smith Estate).
  2. Prepare a transmittal letter by entering the appropriate information
  3. Make copies of both the completed claim form and the completed transmittal letter to the appropriate clerk of court by certified mail.
  4. Attach the certified mail receipt to the claim copies when it is returned by the post office.
  5. Retain all materials in the Creditor’s Claim file until the account balance is paid. After payment all materials should be stored and preserved as required by existing retention policies.

1. **Disputed Claims**

Any dispute regarding the cost of hospital services will be referred to the Director of Finance and/or CEO All settlements will be approved by Director of Finance and/ or CEO in keeping with the Medical Center’s policies. If necessary, disputed claims will be referred to the CEO and/or Hospital Attorney.

1. **Refunds**

Refund payments to individuals will be made only after settlement of all previous bad debt accounts and active accounts.

Any exceptions to the policy must be approved by the CEO or designee.