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Owner Shelly Twilligear

Area Business Office

Applicability United Regional
Hospital and Lab

Business Office Billing and Collection Practices

1. PURPOSE:

1. To ensure the collection of the cost of services rendered in a proper time frame and to provide a consistent system which will enable all patients regardless of race, creed, sex, national origin, age, handicap or source of payment to receive accommodations and treatment when medically indicated and to provide those patients with information supporting services received.

2. POLICY INFORMATION:

1. Provides information regarding United Regional Health Care System, Inc. ("Hospital") policy on Insured, Uninsured, Uninsured Discounting, Patient Billing, Patient Complaints, Employee Payroll Deductions and Financial Assistance.

3. DEFINITION OF POLICY:

3.1. Patients with Insurance Coverage – Insured Patients:

1. Patients will be asked for all insurance information and requested to sign an authorization to bill their insurance when registering or being admitted to the hospital.
2. Prior authorization or pre-certification for treatment is required for some insurance coverage. Patients should discuss this in advance with their physician and contact their insurance company to ensure treatment coverage. In some cases, insurance will not pay for hospital costs if the service is not pre-certified prior to receiving the service. Scheduled services (non-emergent) may be rescheduled until insurance coverage requirements are met. The hospital's filing of claims with the patient's insurance does not guarantee coverage.

3. We will file on all assignable hospitalization medical coverage for hospital related medical claims. Time extension for insurance payment will be terminated after all hospital claim information has been submitted and the reasonable waiting period lapsed. The patient will be responsible for all unpaid charges provided medical documentation substantiates the charges and treatment provided. See section 3.5 for excluded services.
4. Payment of the patient's estimated share will be requested upon admission or discharge if not elective service. This will include co-pay, deductible, coinsurance, and any non-covered charges. The patient's financial obligation is estimated by considering all known medical coverage and payer reimbursement benefits.
5. Payment arrangements may be possible after exhausting all payment resources. Questions and/or problems should be referred to the Collection Manager, Customer Service Coordinator, or Patient Financial Consultant.
6. Non-assigned insurance policies or non-contracted insurance policies requiring hospital acceptance of payment at reduced rates will be treated as self pay for financial obligation purposes unless a single case agreement can be reached and the non-assigned coverage will be counted as a resource when applying for the hospital assistance program or discount policy.
7. Liability information must be taken on all third party payers. Tricare will not process medical claims involving accidents without a completed accident form. Medicaid and Medicare require filing of liability with a mandatory set number of hold days for possible liability payment before allowing the hospital to file Medicare or Medicaid claims. Liens will be filed on all applicable claims as permitted by law.

3.2. Patients without Insurance-Uninsured Patients:

1. Total payment of estimated charges will be requested on preadmission or registration.
2. Patients filing for SSI or SSDI benefits must be screened through the hospital third party eligibility vendor or provide proof of application in process to be eligible for financial extension for medically needed services.
3. The patient is required to exhaust all resources of payment by cash, Visa, MasterCard, Discover, or American Express. The hospital offers check/credit card by phone and payment options with an automatic draft which may also be accessed on the hospital's website. The hospital also has an ATM Machine available for patient's convenience.
4. When full estimated payment cannot be made, the patient and/or guarantor will be screened for eligibility for other medical coverage programs, hospital's financial assistance program, uninsured discounts, or possible payment plan program. EMTALA regulations will be followed for Emergency Room Services and other applicable emergent services.
5. Patients requiring non-emergency medically necessary services that are unable to pay in full or partial and have exhausted all resources for eligibility or payment such as third party eligible screening for state programs, the hospital financial assistance program, county indigent eligibility or any other type of medical assistance program may arrange for a monthly payment plan and may be eligible for an uninsured discount. An initial payment of 30% is requested on admission with consecutive payments due every 30 days until financial obligation is paid in full will be expected.

3.3. United Regional Health Care System Inc. Financial Assistance Program:

1. The hospital has a contract with a third party eligibility vendor that reviews all uninsured or under-insured patients for possible eligibility for medical coverage through any state, county, or federal program. If applicable, patients requesting financial assistance must cooperate with the hospital's third party eligibility vendor to exhaust any possible medical coverage. This vendor will follow all of the hospital's compliance guidelines.
2. Patients with a scheduled procedure requesting financial assistance must complete and present income verification prior to service scheduled date. The Financial Counselor or other applicable personnel will assist the patient or guarantor with any questions regarding completion of the application form or type of income verification needed. The application with proof of income may be mailed, faxed, emailed or returned to the Business Office during regular Business Hours Monday through Friday, 8:00AM to 4:30PM.
3. A Financial Assistance section is available for completion on the reverse side of all monthly patient statements. All patients receiving monthly statements for their financial obligation with a delinquent balance will receive a final demand for payment letter that will also include a reference informing them of the possibility of eligibility under the hospital's financial assistance program.
4. To be considered for financial assistance as a Financially Indigent patient, a person must be unable to pay and have total gross household income at or below 200% of the current federal poverty guideline. If determined to be eligible, up to 200% of the current federal poverty guidelines will be eligible for 100% reduction and 201% up to 400% will be eligible for 65% reduction. Please refer to the Hospital's Financial Assistance Policy for full details. All policy requirements must be met along with the income limits.
5. To be eligible for reduced care under the hospital's financial assistance as Medically Indigent, the patient must not have the means to pay their financial obligation after payment by third party payers, the patient's total gross household income must fall within 201% to 400% of the current poverty income guidelines. Household incomes exceeding 400% of Federal Poverty Guidelines will only be considered for reduction if their financial responsibility exceeds 20% of their annual income. All eligible patients will receive 65% reduction. Please refer to the Hospital's Financial Assistance Policy for full details. All policy requirements must be met along with the income limits.
6. A report capturing uninsured emergency room and other services meeting specific criteria for low income will automatically meet eligibility for 100% discounted services under the Hospital's Financial Assistance Policy.
7. Patients submitting an application for financial assistance will have 120 days to provide a complete application form with any required documentation. Incomplete applications will receive a final notice with a copy of the Hospital Financial Assistance Policy Summary and will have no more than 30 days to complete required information for a determination or a payment to avoid further collection action through an assigned collection agency. If the additional information is received prior to the end of 240 days, collection efforts will be ceased and the application will be processed for final determination.

8. Prior Service Dates past the 240 day application period with no financial assistance application or that were previously denied will not be eligible for reapplication or included with any new financial assistance application. Only the outstanding financial obligation will be considered under the new financial assistance application and refunds of prior payments on services past the 240 day application will not be made.
9. Patients whose services are considered to be cosmetic and/or not medically necessary, non-covered screenings or designated as a "cash" only procedure will not be eligible for the Hospital's Financial Assistance Program.

3.4. Uninsured Discounting Policy:

1. **Discount-Uninsured patients** who are NOT eligible for the hospital charity program will be eligible for the following discount plans which will be applied after completing full payment of discounted financial obligation.
2. Uninsured patients are those who do not have funding for medical expenses provided by any outside source including, but not limited to, any commercial or managed care insurance coverage (individual or group policy); any third-party insurance coverage; any employer funded coverage; any federal or state funded coverage.
3. The reduction of account charges for uninsured patients shall apply to emergent or other medically necessary health care services rendered to the patient.
4. Uninsured patients will received an uninsured discount based on date of service and billed charges at the time of billing. Effective January 1, 2021, discount 30% applied, dates of service February 1, 2022 will have 50% discount applied at time of billing.
5. Special Discounting for Clinic (Outpatient) Services for MRIs and CTs and any related contract.
 - a. A 50% discount will be applied if paid in full at time of service and no insurance is filed.
 - b. No other discount will be eligible for these services when accepted under these terms.
 - c. Filing of insurance will void the 50% discount and it will be reversed on the patient account.
 - d. This discount is only available for outpatient "Clinic" services and does not apply to Outpatient Surgery or outpatient Observation Services.
6. Patients under the following categories are NOT eligible for uninsured discounts.
 - a. Patients who are eligible for the hospital's Financial Assistance Program.
 - b. Patients who have coverage under Medicare, Medicaid, Tricare, Managed Care, DARS, the hospital's Self –Funded coverage, County Indigent, Pre-established Hospital Cash Rate, or under any other coverage that prohibits patient share discounts.

3.5. Cosmetic or Non-Covered Elective Procedures:

1. Preset Discounted Cash Procedures require payment of 100% prior to services. For all others, the patient is required to pay 70% of the average procedure estimate prior to services being

rendered.

2. Financial arrangements must be made on the allowable unpaid balance as follows with a minimum monthly payment of \$50:
 - a. First Payment due no later than 30 days from discharge date.
 - b. Consecutive monthly payment due every 30 days until obligation paid in full.
 - c. See Section 3.4 for possible discount eligibility.
3. Patients' physician will always be consulted prior to any cancellation or rescheduling request.
4. Any variance must be authorized by Director or Administration.

3.6. EMERGENCY ROOM CARE:

1. All Emergency Room Levels of charge will be dependent upon the treatment ordered and received and applied to the hospital E/M level guidelines. These guidelines are applicable to all Emergency Room Level Charges regardless of the area of treatment.

3.7. EMERGENCY ROOM PHYSICIAN CHARGES AND BILLING:

1. The Emergency Room Physician charges are not included on the hospital bill and will be billed separately through the Emergency Room Physician Group which is a separate provider. The Emergency Room Physician Group may not be in the same payer network as the hospital according to the specific insurance payer. The hospital will provide the network list and encourage the Emergency Room Physician's to participate in the same payer's network.
2. The providers under the Emergency Room Physician Group are not covered by the Hospital's Financial Assistance Policy.

3.8. Other Provider Services:

1. The patient may experience a variety of tests, procedures, and services during their visit to the hospital. Many of these services are performed by health-care providers who work in the hospital but bill for their services separately. The patient may receive bills from several different health-care providers, such as hospitalist, anesthesiologist, radiologist, pathologist, ER physician, and the patient's physician(s) which could be in or out of network in relation to their insurance coverage.
2. The providers listed above are not covered by the Hospital's Financial Assistance Policy.

3.9. Patient Billing & Statements of Patient Charges:

1. A written disclosure according to Senate Bill 1731 will be given to all patients or applicable guarantor upon admission or as appropriate for emergent or diagnostic services. This disclosure will provide the patient/guarantor with information as to whether the hospital is a participating provider under the patient's third party payer coverage. This disclosure will also inform the patient/guarantor that they may be treated by a physician or other health care

- provider while receiving services in that hospital that may Not be a participating provider.
2. Per Senate Bill 490 an itemized bill with codes will be mailed or sent electronically to patient with any request for payment, additionally an itemized statement will be mailed within two business days to all patients and/or guarantor upon request. This request may be made by calling the Business Office Monday through Friday from 8:00 a.m. through 4:30 p.m.
 3. Once all insurance claims have been finalized by payment or denial or the time allowed for finalization has exhausted; patients will be mailed a series of monthly statements along with staff and automated collection calls when appropriate until financial obligation has been met.
 4. If no other hospital service financial obligation, Patient Refunds for over-payment of a hospital account will be refunded within 30 days from the date determination of an over-payment has been verified.
 5. Currently, the hospital does not charge patients any interest for financial obligations.
 6. In compliance with Senate Bill 1731, a Notice informing patients/consumers of our policies relating to billing of services, discounting for uninsured patients, financially and indigent charity guidelines, provision of an itemized statement, hospital interest, process for patient complaints, patient request for written estimates for elective services, and disclosure of participating provider coverage per service dates will be posted in the waiting area of each admission area on site and off site as well as the Business Office waiting area.
 7. The hospital may at times use an outside vendor for Patient or Insurance Billing purposes. Any vendor selected must sign a Business Associate Agreement.

3.10. Charge and/or Service Questions and/or Complaints from Patients or Guarantors:

1. The actual charges for service will vary based on the patient's medical condition and other factors associated with performance of the procedure or service.
2. The actual charges may differ from the amount to be paid by the patient or the third party payer.
3. The patient may be personally liable for payment depending upon the patient's insurance plan coverage.
4. The patient should contact their insurance for accurate information regarding the plan structure, benefit coverage, deductible, co-payment, coinsurance, and other plan provisions that may impact the patient's liability for payment for the services.
5. Patients with questions or complaints regarding patient satisfaction with care, charges or accommodations will be referred to the appropriate department to review for response, auditing process, and /or coordination of resolution through our hospital's Patient Representative Department.
6. Face to face communication is encouraged by the patient or the patient's legally designated representative with the nurse, the manager of the patient care areas, director of the patient care area, Business Office Manager or Director, Patient Relations representative.

7. Any safety or quality of care concern that a staff member has not satisfactorily resolved can be addressed by contacting Patient Relations at 764-3685.
8. Charging complaints will be reviewed if applicable by utilizing the appropriate personnel and department of services and reviewing the Billing Record and Medical Record for physician orders and service documentation.
9. When appropriate, complaints will also be referred to the hospital's Patient Relations for additional review regarding clinical and/or physician complaints.
10. When applicable, corrections to the patient's bill as well as re-filing a corrected claim to the patient's insurance will be made.
11. Patients whose concerns have not been resolved after exhausting the hospital's complaint resolution process will be provided with contact information for the Texas Department of State Health Services (TDSHS), 1100 w 49th Street, Austin, Texas and informed that they may file their complaint with TDSHS by calling 1-800-913-0022.

Approval Signatures

Step Description	Approver	Date
Final Reviewer	Jeri Kaspar	2/2/2024
First Reviewer	Shelly Twilligear	2/2/2024
	Shelly Twilligear	2/2/2024

Applicability

United Regional, United Regional Laboratory

Standards

No standards are associated with this document