



## MEMORIAL HEALTH SYSTEM

<b>Title:</b>	<b>Billing and Collection</b>
<b>Applies to:</b>	<b>Memorial Health System</b>
<b>Department:</b>	<b>Finance</b>
<b>Date Reviewed:</b>	
<b>Reviewer:</b>	
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<b>Reviser:</b>	<b>Melissa Athey</b>
<b>Document Type:</b>	<b>Procedure</b>

- I. Purpose:** In keeping with its founding mission, Memorial Health System provides financial assistance to those without the financial resources to fulfill their payment obligations for medically necessary health care services receives at Memorial Health System facility (see listing of Covered Facilities). This policy sets forth payment expectations, payment options, and actions that may be taken for non-payment on patient accounts that do not qualify for financial assistance. MHS will not take extraordinary collection actions (ECA) against a patient to obtain payment before reasonable efforts have been made to determine if the patient qualifies for financial assistance under the MHS Financial Assistance policy (see “Access” section for obtaining the policy and application).
- II. Terms and Definitions:**
- a. AGB-** Amounts Generally Billed for emergency or other medically necessary services to patients who have insurance. AGB are updated annually by MHS.
  - b. Application Period:** The time period in which MHS must accept a financial assistance application. The 240 day period begins after the first post discharged bill date. A 30-day notice must be given pursuant the ECA.
  - c. Charity:** A hospital specific financial assistance program based on FPG and AGB.
  - d. ECA:** Extraordinary collection actions that MHS may take to obtain payment on an account and could include legal or judicial actions such as reporting adverse information to collection agencies and/or credit bureaus.
  - e. FPG:** Federal Poverty Guidelines established by the U.S. Department of Health and Human Services. FPG are updated annually.
  - f. HCAP:** Hospital Care Assurance Program is specific to the State of Ohio and sets forth the criteria to provide free medically necessary services to patients who are residents of Ohio with income below the FPG.
  - g. Insured:** Patients with insurance or other third party coverage (regardless of whether the patient chooses to use insurance for service).
  - h. RevMD:** An outside third party that assists MHS with collection efforts. RevMD follows and applies the MHS Billing and Collections policy and the Financial Assistance policy.
  - i. Uninsured:** Patients with no insurance coverage (self-pay).
- III. Required Equipment:** Non-applicable.
- IV. Step by Step Description:**
- a. Reasonable Efforts to Determine Financial Assistance Eligibility:** MHS will not engage in ECA against the patient without first making reasonable efforts to determine if the patient qualifies for financial assistance.

- i. All patient statements will have all information on how/where to access the financial application and policy, and the application will also be on the back of patient statements.
- ii. The Financial Assistance policy, application, and Billing and Collection policy will be posted on the MHS public website.
- iii. A plain language summary of the Financial Assistance policy will be posted on the MHS public website and also is available at registration and other points of patient entry.
- iv. If a previously approved application for financial assistance is on file within the last three months, subsequent accounts will be reviewed to determine if the application on file will cover those accounts.
- v. A hospital representative meets with inpatients during their stay to see if they are possibly eligible for Medicaid, and if not, initiates the financial assistance process and leaves a plain language summary with the patient. Hospital staff/registrars will orally communicate with patients regarding the availability of financial assistance and refer them to the plain language summary.

**b. Amounts Generally Billed:**

- i. A patient eligible for financial assistance under this policy will not be billed for full gross charges or amounts generally billed. MHS uses the “Look-back Method” as set forth by the IRS 501r regulations to determine the amount generally billed to insurance payers and is reflected in the sliding scale used to apply the charity discount. Annually, MHS evaluates the AGB and adjusts the sliding discount scale accordingly so that uninsured patients are not expected to pay more than insurance.

**c. Patient Statement Cycle**

- i. First statement is typically sent out within 7 days of discharge after charges and coding is completed on self-pay accounts. First statement for self-pay after insurance is sent out after the insurance payment is received and posted to the account.
- ii. Second through fifth statements are sent every 30 days until account is paid in full or qualifies for collections.
- iii. Patients are provided a 30-day notice on the statement, that the account could be placed with a collection agency if not paid in full or if payment arrangements are not made.

**d. Actions taken for nonpayment:** The following actions apply to self-pay (uninsured) and self-pay balances after insurance payment.

- i. Patients will receive 5 statements within a 120 day period from MHS.
- ii. Self-pay balances greater than 120 days qualify to be placed with a collection agency. Accounts remain at the collection agency for one year or until the account is settled in full through an established payment plan.

**e. Refund of Patient Payment:** If a patient qualifies for HCAP, all patient payments made must be refunded and cannot be applied to other outstanding account balances. If a patient qualifies for Charity, patient payments in excess of the AGB must be refunded (unless <\$5.00). Patient payments for non-eligible services or non-covered facilities do not have to be refunded.

**f. Other Discounts Available:** MHS has other discounts and incentives available for pre-service, time of service and uninsured. More information is available in Self-Pay Collections and Patient Financial Obligation and Discount Policies. Please contact a patient account representatives at (740) 374-1413 for additional information.

**V. Associated Forms, Documents, and/or Interventions:**

- a. **Payment Plans:** MHS offers interest-free payment plans for patients who need to make monthly payments in order to pay outstanding patient balances. Cosmetic and Bariatric services are not covered under this payment plan arrangement.
  - i. Balances less than \$500 should be paid in full within 6 months.
  - ii. Balances between \$500-\$1,500 should be paid within 12 months.
  - iii. Balances between \$1,501-\$2,500 should be paid within 18 months.
  - iv. Balances between \$2,501-\$5,000 should be paid within 24 months.
  - v. Balances between \$5,001-\$10,000 should be paid within 36 months.
  - vi. Balances >\$10,000 requires \$350 monthly minimum payment.
- b. **Covered Facilities:**
  - i. This policy applies to the following:
    - 1. Marietta Memorial Hospital (includes hospital-based clinics/physicians and Belpre)
    - 2. Selby General Hospital
    - 3. RevMD (Early out/Collections representatives of MHS)
  - ii. These entities are covered under the MHS financial assistance policy, but have their own Billing and Collections practices (not covered under this policy):
    - 1. Medac (Anesthesia Services)
    - 2. Professional Billing Services (Dr. Macatol)
    - 3. Riverside Radiology (Imaging Services)
  - iii. Non-hospital based clinics/physicians and physicians in private practice are not covered under this policy or the MHS financial assistance policy.
- c. **Emergency Services:** All patients shall receive, without discrimination, care for emergency medical conditions, screening examinations, stabilizing treatments, and referring/transferring to another facility when appropriate regardless of ability to pay or whether they are financial assistance eligible. Please see the “EMTALA-Medical Screening” policy for additional information.
- d. **Eligible Services:** Emergency Care and Medically necessary services are covered under this policy. Services not covered include: services deemed not medically necessary, cosmetic services, bariatric services, infertility services, and charges with non-covered revenue codes per the Ohio Administrative Code Appendix A.
- e. **Access to Policies and Financial Assistance Application:** The application and policies are available at:
  - i. MHS 401 Matthew Street, Marietta Ohio 45750
  - ii. SGH 1106 Colegate Drive, Marietta Ohio 45750
  - iii. Financial Counselor (740) 568-5263
  - iv. Public Website: [www.mhssystem.org](http://www.mhssystem.org)
  - v. Email request to: [financialassistance@mhssystem.org](mailto:financialassistance@mhssystem.org)
- f. **Other Considerations:** MHS may elect to re-evaluate applications not approved for financial assistance based on Charity requirements above. In situations such as hardship, catastrophic circumstances, etc. MHS may grant Charity to all or a portion of the patient’s medical bill.

**VI. References:** Non-applicable.

Approved By: Chief Financial Officer

<b>Endorsements:</b>		<b>Finance Committee</b>	
<b><u>Regulating or Accrediting Organization:</u></b>		<b><u>Standard</u></b>	
Healthcare Facilities Accreditation Program (HFAP)		# :	
Ohio Department of Health (ODH)		# :	
Centers for Medicare and Medicare Services (CMS)		# :	
Other:		# :	