

Billing and Collections Policy

SUBJECT: MHS Billing and Collections Policy
DEPARTMENT: PATIENT FINANCIAL SERVICES
PREPARED BY: Financial Assistance Committee
REVIEWED BY: Kathryn Keim
APPROVED BY: MHS Board of Directors

REFERENCE
EFFECTIVE DATE:
10/01/2016
LAST REVIEWED:
10/01/2020

POLICY:

Memorial Health System (MHS) and its affiliates (as defined in the MHS Financial Assistance Policy and collectively referred to as “MHS or MHS Affiliate(s)”) are committed to providing the highest quality of healthcare and service to the patient in a cost-effective manner. After our patients have received services, it is the policy of MHS to bill patients and applicable Payers accurately and in a timely manner. All outstanding accounts will be handled in accordance with the IRS and Treasury’s 501(r) final rule under the authority of the Affordable Care Act and will be compliant with all federal and state laws and regulations. MHS will accept all emergent patients and provide the needed care without financial considerations. MHS management has the authority to make exceptions to this policy on a case-by-case basis, for special circumstances.

PURPOSE:

It is the goal of this policy to provide clear and consistent guidelines for conducting billing and collection functions in a manner that promotes compliance, patient satisfaction and efficiency. Through the use of billing statements, written correspondence and phone calls, MHS will make diligent efforts to inform patients of their financial responsibilities and available financial assistance options. Additionally, this policy requires MHS to make reasonable efforts to determine a patient’s eligibility for financial assistance under MHS’s Financial Assistance Policy before engaging in Extraordinary Collection Actions (ECA) to obtain payment.

DEFINITIONS:

Billing Deadline (Final Notice): The date after which MHS may initiate an ECA against a responsible individual. The billing deadline must be specific, in a written notice to the responsible individual and provided at least 30 days prior to the deadline, but no earlier than the 120 days from the first post-discharge statement.

Extraordinary Collection Actions (ECA): A list of collection activities, as defined by the IRS and Treasury, that healthcare organizations may only take against an individual to obtain payment for care after Reasonable Efforts have been made to determine whether the individual is eligible for financial assistance. These actions are further defined in the Reasonable Efforts and Extraordinary Collection Actions (ECA) section of this policy, and may include actions such as reporting adverse information to credit bureaus/ reporting agencies, along with legal/judicial actions such as garnishing wages.

Financial Assistance Policy (FAP): A separate policy that describes the MHS financial assistance program, including the criteria patients must meet in order to be eligible for financial assistance, as well as the process by which individuals may apply for financial assistance.

Payer: Entity other than the patient that finances or reimburses the cost of health services. In most cases, this term refers to an insurance carrier, other third-party payer or health plan sponsor (employer or union).

Patient Responsibilities: Any portion of a patient account that is the responsibility of the patient or other responsible individual(s). This responsibility is determined after application of payments made by any available healthcare insurance or other third-party payer (including payments for copayments, coinsurance and deductibles), and all discounts under the FAP.

Plain Language Summary (PLS): A written statement that notifies an individual that MHS offers financial assistance under its FAP for medically necessary hospital services. The PLS provides information on accessing and obtaining assistance under the FAP. The PLS is made available during the patient intake and/or discharge process.

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DEFINITIONS (cont'd):

Reasonable Efforts: A certain set of actions a healthcare organization must take to determine whether an individual is eligible for financial assistance under the MHS FAP. In general, reasonable efforts may include making presumptive determinations of eligibility for assistance, as well as providing individuals with written and oral notifications about the FAP and application processes.

Uninsured: Patient of a hospital who is not covered under a policy of private health insurance, health benefit or other health coverage program, including high-deductible health insurance plans, workers' compensation, accident liability insurance or other third-party liability.

PROCEDURES:

Patient Access

Preregistration

MHS will strive, whenever possible, to preregister patients in advance of their services and shall verify identity and demographic information, eligibility, obtain pre-certifications and validate medical necessity.

Prior Authorization (Pre-Certification)

Most insurance companies require the patient's physician or insurance policyholder to obtain authorization prior to receiving hospital services. If the insurance company has such a requirement, the patient must confirm with his/her physician or insurance company that prior authorization has been secured. Failure to secure required prior authorization may result in partial or complete denial of insurance benefits for the hospitalization. The patient may be responsible for payment of any denied charges due to lack of prior authorization.

Registration

At time of service for all non-preregistered patients, MHS will collect all available admission data and, whenever possible, verify all registration data through the most efficient and timely manner.

Presumptive Eligibility Screening

Patient Access staff will screen all Uninsured patients for 100% financial assistance at registration, when possible. See FAP for Presumptive Eligibility criteria and screening.

Plain Language Summary

All registered patients will be offered a copy of the MHS Plain Language Summary.

Financial Counseling

Financial counselors are available to assist patients with Medicaid and financial assistance applications.

Collecting at Point of Service

MHS has a philosophy of seeking collection of identified Patient Responsibilities at, or before, time of service, as long as such collection does not impede the rendering of care. Patients presenting for elective services may be asked to pay coinsurance and/or deductibles in advance.

Insurance Billing/Follow-up

For all insured patients, MHS will bill applicable Payers (based on information provided by or verified by the patient) in a timely manner. Accounts billed to Payers are followed up in a timely manner, requesting a response or payment in full.

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Patient Billing/Follow-up

Determining Patient Responsibilities

MHS will reserve the right to determine Patient Responsibilities based upon Payer contractual obligations and/or federal and state reimbursement requirements. Should MHS dispute a Payer payment, MHS staff will investigate the dispute and take necessary action before pursuing payment from the patient. If a claim is denied (or is not processed) by a Payer due to MHS error, MHS will not bill the patient for any amount in excess of what the patient would have owed had the Payer paid the claim. If the Payer issue was not related to a MHS error, MHS reserves the right to bill and collect from the patient.

Billing/Follow-up

All accounts with a patient responsibility will be billed in a timely manner. The patient may receive a phone call regarding payment. Contact with the patient will include information regarding MHS's FAP.

Patient Statements

Notices and/or statements will be issued to the patient on a monthly cycle and will contain the website URL for FAP information.

Call Center

MHS will maintain a customer call center to answer incoming patient calls. This center will provide quality customer service and assist patients with making payments, answering questions or handling disputes.

Itemized Bills

All patients may request an itemized bill for their accounts at any time.

Patient Disputes

If a patient disputes the bill, staff members will provide the requested documentation in writing within 7 days (if possible) and will hold the account for at least 30 days before referring the account for collection.

Payment Methods and Other Resources

Cash and Checks

Personal checks are accepted, but must be preprinted with the Payer name, Payer address, bank name, branch, bank address, encoded ABA and MICR. Certified checks, cashier's checks, bank drafts, money orders and traveler's checks are also accepted. Foreign currency will not be accepted.

Credit Cards

MHS will accept Mastercard, Visa or Discover cards. Credit card payments will be accepted upon approval of the issuing authority and subject to the credit card's restrictions.

Payment Plans

MHS may approve payment plans. MHS is not required to accept patient-initiated payment arrangements and may refer accounts to a collection agency, as outlined below, if the patient is unwilling to make acceptable payment arrangements or has defaulted on an established payment plan. Patient statements will include the phone number of the office that can assist the patient in making payment arrangements.

Bank Loans

MHS will assist patient in accessing long-term financing through financial institutions external to MHS.

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Outsource Agencies

MHS may engage independent companies to assist in the collection and resolution of outstanding accounts. Agencies will adhere to MHS policies and guidelines and state and federal laws and regulations.

Refunds

MHS will identify all credit balances and refund credit balances within applicable federal and state statutes and regulations.

Collections Practices

In compliance with relevant state and federal laws and regulations, and in accordance with the provisions outlined in this Billing and Collections Policy, MHS may engage in collection activities, including Extraordinary Collection Actions (ECA), required to collect outstanding Patient Responsibilities. Patient Responsibilities may be referred to a third party for collection at the discretion of MHS. MHS will maintain ownership of any debt referred to debt collection agencies. MHS has a code of conduct policy that sets forth certain principles to which agencies, representatives and collectors are expected to adhere.

A patient's account will be referred to collection, with the following caveats:

1. There is a reasonable basis to believe the patient owes the debt.
2. All Payers have been properly billed and the remaining debt is the Patient Responsibility.
3. MHS will not refer accounts to collection while a claim on the account is still pending Payer payment. However, MHS may classify certain claims as "denied" if such claims are stuck in "pending" mode for an unreasonable length of time, despite efforts to facilitate resolution.
4. MHS will not refer accounts to collection where the patient has initially applied for financial assistance or other government-sponsored programs and MHS has not yet notified the patient of its determination, provided the patient has complied with the timeline and information requests delineated during the application process as identified under the FAP.
5. The MHS FAP does not apply to the portion of services that have been, or may be, paid for by an automobile or liability insurance. As allowed by the State of Illinois, when a patient presents for services following an accident or injury, MHS may place a hospital lien against the third-party settlement.

Reasonable Efforts and Extraordinary Collection Actions (ECA)

Before engaging in ECA to obtain payment for care, MHS must make certain Reasonable Efforts to determine whether an individual is eligible for financial assistance under our Financial Assistance Policy, including the following:

1. ECAs may begin only when 120 days have passed since the first post-discharge statement was provided.

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2. At least 30 days before initiating ECA to obtain payment, MHS shall do the following:
 - Provide the individual with a written final notice that indicates the availability of financial assistance, lists potential ECAs that may be taken to obtain payment for care and gives the Billing Deadline.
 - Provide a Plain Language Summary of the FAP, along with the notice described above.
 - Attempt to notify the individual orally about the FAP and how he or she may get assistance with the application process.
3. ECA will be suspended if the FAP application is submitted within 240 days of the first post-discharge statement. Those ECA may be activated again if the individual is found to not be eligible for financial assistance. If the application is incomplete, MHS will send the individual a written notice that describes the additional information or documentation required under the FAP.
4. After making Reasonable Efforts to determine financial assistance eligibility, as outlined above, MHS (or its authorized business partners) may take the following ECA to obtain payment for care:
 - Legal action, credit bureau reporting or court judgment wage garnishment.
5. The patient will be responsible for any fees incurred to take an ECA to receive payment.

Financial Assistance

MHS offers financial assistance information free of charge. To request a copy, or for more information, contact the MHS facility below:

Memorial Medical Center

- In person at the Patient Financial Services Lobby Office at 701 N. First St., Springfield, IL 62781
- By calling the Financial Assistance Representative at 217-788-4774 or toll-free at 800-562-2829
- By emailing a request to Financial.Assistance@mhsil.com
- By mailing a request to: Memorial Medical Center, Attn: PFS Department, 701 N. First St., Springfield, IL 62781
- Online at MemorialMedical.com/FinancialAssistance

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Decatur Memorial Hospital

- In person at Patient Financial Services Office at 2300 N. Edward St., Decatur, IL 62526
- By calling Patient Financial Services at 217-876-3785
- By emailing a request to DMHFinancialAssistance@mhsil.com
- By mailing a request to: Decatur Memorial Hospital, Attn: PFS Department, 2300 N. Edward St., Decatur, IL 62526
- Online at DMHCares.com/patient-and-visitor-information/financial-assistance

Passavant Area Hospital

- In person at Patient Financial Services Office at 1600 W. Walnut St., Jacksonville, IL 62650
- By calling the Credit Manager at 217-479-2876 or 217-479-2877
- By emailing a request to PAHFinancial.Assistance@mhsil.com
- By mailing a request to: Passavant Area Hospital, Attn: PFS Department, 1600 W. Walnut St., Jacksonville, IL 62650
- Online at PassavantHospital.com/FinancialAssistance

Abraham Lincoln Memorial Hospital

- In person at Patient Financial Services Office at 200 Stahlhut Drive, Lincoln, IL 62656
- By calling Patient Financial Services Office at 217-788-3370
- By emailing a request to ALMHPatientAccounts@mhsil.com
- By mailing a request to: Abraham Lincoln Memorial Hospital, Attn: PFS Department, 200 Stahlhut Drive, Lincoln, IL 62656
- Online at ALMH.org/FinancialAssistance

Taylorville Memorial Hospital

- In person at Patient Financial Services Office at 201 E. Pleasant St., Taylorville, IL 62568
- By calling Patient Financial Services at 217-788-3370
- By emailing a request to TMHPatientAccounts@mhsil.com
- By mailing a request to: Taylorville Memorial Hospital, Attn: PFS Department, 201 E. Pleasant St., Taylorville, IL 62568
- Online at TaylorvilleMemorial.org/FinancialAssistance