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Great River Health System

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Owner:	*Shannon Leffler: Manager-Patient Billing*
Area:	*Policy - Administrative*
Applies To (Select All):	*Ft. Madison Community Hospital, Great River Clinics, Great River Health System, Great River Medical Center, Home Care/Hospice, Hospital, Hospital-Based Clinics, Klein Center*

Patient Balance Policy

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PURPOSE

To provide consistent, compliant, and efficient processing of patient balance accounts after all appropriate third party sources have been exhausted. Great River Health System's practices support our commitment to our patients and ensure patients are billed in a fair, accurate, and timely manner in compliance with the Patient Protection and Affordable Care Act of 2010 (PPACA).

POLICY

It is the policy of the health system to only bill for services performed and items used in the care provided. It is the policy of the health system to ensure all resources are used in the billing of our patients and all efforts are made to simplify the billing process as much as reasonably possible.

STATEMENTS

1. A monthly self-pay statement is provided to the guarantor of each patient when the balance becomes the responsibility of the guarantor.
   a. The guarantor of an account can be, but is not limited to, a parent of a child under the age of 18, a parent of a dependent child over the age of 18, a spouse of a deceased patient (see guidelines in relation to deceased patients below), or a responsible party not listed above but provided to the health system.
      i. The health system does not take into consideration divorce decrees or other legal documents in relation to support of a minor child. Both parents are held equally responsible for balances of a minor child. Typically, the parent who brings the child for services is named the guarantor and is responsible for payment at point of service.
   b. Separate statements are provided for GRMC, GRPC, and FMCH.
2. Statements are sent by paper or electronic form, which includes text reminders and email reminders.

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1. Patients can choose to receive paper or automated statements by signing into the PatientCo Patient Wallet.
2. Patients can opt out of text reminders by replying **stop** to a text message.
3. Patients can opt out of email reminders by selecting **unsubscribe** at the bottom of the email.

3. The initial statement is generated the day after the balance becomes the responsibility of the guarantor. It will include the following:
   a. Itemization of all charges for services performed and care provided
   b. Dates of service for all services
   c. Place of service
   d. Insurance payments and adjustments
   e. Patient payments and adjustments
   f. Total balance due by the guarantor
4. Recurring monthly statements are created every 30 days after the initial itemized statement. They include the following:
   a. A balance-forward amount, which is the balance after the last statement
   b. The encounter date of service
   c. The encounter place of service
   d. All insurance and patient payments and adjustments that are made after the previous statement.
5. Additional itemized statements are available:
   1. On request through Patient Financial Services–Patient Billing. The itemized statement will be provided to the guarantor within seven days of the request. It may not be possible to provide itemized statements before the current year. Those statements are provided in the initial billing. These requests will be considered individually.
   2. Patients/guarantors can access statements through the PatientCo Patient Wallet, which can be found on our websites, https://www.greatriverhealthsystem.org/Online_Bill_Pay and https://www.fmchosp.com/patients-visitors/online-bill-pay/

DECEASED PATIENTS

1. Billing for deceased patients:
   a. A lien will be filed against the estate of the deceased patient if such estate exists.
   b. In the absence of an estate or in the event that estate assets are exhausted and in accordance with Iowa Code 252A.3:
      i. A spouse is liable for the medical expenses of the deceased spouse.
      ii. A parent is liable for the medical expenses of a deceased child under the age of 18.
      iii. A parent is liable for the medical expenses of a deceased dependent child 18 years of age or older.
   c. At no time will other family members 18 years of age or older be held responsible for outstanding balances of a deceased family member **unless** they meet the above criteria.

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Discounts

1. Financial assistance discounts (refer to our full financial assistance policy):
   a. Patients who qualify for financial assistance may receive discounts up to 100%.
   b. Financial assistance discounts are based on guarantor balances and not applied to charges billed to insurance companies.
2. Financial assistance discounts may not be considered for guarantor balances if the patient's insurance is out of network with the health system and the patient had the option to seek care or transfer to a facility within their insurance's network but chose not to.

PAYMENT EXPECTATIONS

1. Payment is expected at the time of service. Patients may be removed from the schedule or rescheduled if payment is not received.
2. Payment in full is required for elective procedures. This payment must be made before services are received or the patient will be removed from the schedule.
   a. Elective services include, but are not limited to, services that are not deemed medically necessary.
3. Patients who have insurance that the health system does not contract with may be expected to pay for their services in full at the time of service. This includes out of state Medicaid.
4. Payment in full for outpatient services may be required for patients who have balances with an outside collection agency.
5. It is our policy that balances be paid in full within 12 months of the date of the first statement. If the guarantor enters into a payment plan after the first statement the payment plan will be figured for the number of months that are left in the 12-month period from the date of the first statement. Example: if the plan starts after the third statement then there are nine months available for a payment plan.
   a. If payments are made consistently each month but do not resolve the balance 30 days from the date of the 12th statement then the final payment will be for the remaining balance.
   b. If the final payment is not received or does not resolve the balance then account will be turned to an outside collection agency.
6. Patients can sign up for electronic automated payments/payment plans as long as the payments meet the policy guidelines listed above.
   a. New balances can be added to electronic automated payment plans at the request of the patient.
   b. Automated payments that default more than once will be removed.
7. Employed patients **(with the exception of FMCH)** can sign up for payroll deduction:
   a. Payments made through payroll deduction can be made for up to 26 pay periods as long as the policy guidelines above are met.
   b. Payroll deduction **cannot** be created for balances that will be paid off in less than 4 pay periods.
   c. New charges greater than $50 can be added to an existing payroll deduction.
      i. New charges that are less than $50 must be paid by other means.
      ii. New charges cannot be added without completion of a new payroll deduction form.

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iii. The final payment of the payroll deduction will be based on the oldest balance.

8. Accepted payment types are cash, check, major credit cards (Visa, MasterCard, Discover, and American Express), flex card, and electronic checks.
9. Ways to pay include:
   a. Mail to our lockbox location with the coupon portion of the statement
   b. 24/7 voice pay service. Call 877-404-4763, option 1. You must have your nine character secure health code, which can be found on your statement.
   c. Online at https://www.greatriverhealthsystem.org/Online-Bill-Pay.aspxor https://www.fmchosp.com/patients-visitors/online-bill-pay/
   d. By telephone with a financial counselor. Call 877-404-4763, option 2.
   e. In person with at financial counselor in patient billing in GRMC's main lobby or FMCH's business office.
   f. By acquiring a Medical Expense loan with the assistance of a financial counselor.
   g. With a Care Credit card.
      a. The health system cannot process these payments. You can visit the Care Credit website by accessing the Online Bill Pay page of our website.
10. The health system will accept payments with a notation of "paid in full" but does not consider such payments as an agreement of paid in full:
    a. Insurance companies have up to seven years to audit payments and recover payment if they find they paid incorrectly. In such an event, the new balance could then become the responsibility of the guarantor. The health system has the legal right to bill the guarantor. Therefore, a previously paid balance with the notation of "paid in full" is considered null and void.
    b. If the amount paid is less than the balance of the statement and the patient writes "paid in full" the patient remains responsible for the outstanding balance.

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INTERNAL COLLECTION PRACTICES

1. Statements are sent monthly.
2. Bill reminders through telephone calls and email are sent by an automated call system.
   a. A patient and/or guarantor can opt out of bill reminder emails by selecting **unsubscribe** at the bottom of the email.
   b. A patient and/or guarantor can opt out of bill reminder calls by calling the Patient Financial Services\-Patient Billing office at 877-404-4763, option 2.

PATIENT RESOURCES

1. It is the policy of the health system to assist patients with all resources that may be available to them. This includes resources such as, but not limited to, electronic automated payment plans, financial assistance, qualification of Presumptive Medicaid or full Medicaid, enrollment in Health Care Marketplace insurance, and enrollment in a medical expense loan.
2. Financial assistance is available to patients who qualify. Qualification is based on federal poverty guidelines. Refer to our financial assistance policy for more detail.

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ASSIGNING OUTSTANDING BALANCES TO AN OUTSIDE COLLECTION AGENCY

1. It is the policy of the health system to exhaust all internal efforts listed above before balances are moved to an outside collection agency acting on behalf of the health system.
2. Balances may be given to an outside collection agency acting on behalf of the health system in the event the patient **does not** do one of the following:
   a. Make payments within 4 statements from the first statement date
   b. Comply with an acceptable payment agreement that requires consistent monthly payments that result in the balance being paid in full within 12 months of the first statement date
   c. Comply with the Financial Assistance Policy
   d. Comply with governmental programs in an effort to obtain medical coverage
3. Outstanding balances with no payment will not be given to an outside collection agency until 120 days from the date the balance became the responsibility of the guarantor.

EXTERNAL COLLECTION PRACTICES DUE TO NON-PAYMENT

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1. Outside agencies acting on behalf of the health system will adhere to all rules and regulations in regards to the Patient Protection and Affordable Care Act of 2010.
2. Outside agencies acting on behalf of the health system will not impose Extraordinary Collection Actions (ETAs) until reasonable efforts to resolve the debt are exhausted and a minimum of 120 days are met.
3. Reasonable efforts:
   a. Validate the patient owes the unpaid balance and all sources of third-party payments have been identified and billed by the hospital
   b. Documentation that the health system has attempted to offer the patient the opportunity to apply for financial assistance pursuant to this policy and that the patient has not complied with the hospital's application requirements
   c. Documentation that the patient has been offered a payment plan but has not honored the terms of that plan
4. Extraordinary collection actions include:
   a. Selling debt to a third party other than a collection agency
   b. Reporting adverse information to a consumer credit reporting agency or credit bureau
   c. Filing a claim for an unpaid debt through the court system
   d. Applying a lien against the guarantor's assets for an outstanding debt

COLLECTION PRACTICES FOR TITLE TEN FAMILY PLANNING PATIENTS

1. Minors receiving services from the Title Ten Family Planning Clinic who prefer to have their services

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remain confidential will not be required to provide a guarantor for billing purposes.

2. Minors seeking confidentiality will have the schedule of discounts applied based on their income alone and the income of a a parent or guardian will not be considered.
3. If services received are out of network with the patient's insurance, the schedule of discounts will still be applied.
4. Patients will not be rescheduled or removed from the schedule due to lack of payment at the point of service.
5. No balances of a minor or patient seeking confidentiality will be assigned to an outside collection agency.

Links to Related Documents

Billing and Collections

Financial Assistance Policy

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
Policy Administrator	Regina Wimley: Executive Assistant	11/2019
Administrator	Jeremy Alexander: Chief Financial Officer	11/2019
	Shannon Leffler: Manager-Patient Financial Svc	11/2019

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