Title: **Inpatient Hospital – Patient Billing and Collection**
Number: **3.3.39**
Area: **Finance**
Effective Date: **06/01/2014**
Revised Date: **05/19/2023**

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**Purpose:**
It is the policy of **Aspire Health Partners, Inc. (AHP)** to establish guidelines to insure that payment on client accounts is pursued consistently and to ensure all patient accounts are collected and written off to bad debt in accordance with Medicare regulations.

**Scope:**
This policy pertains to the Business Office, Patient Accounts and team members performing billing and collection functions and all people served by all representatives of Aspire Health Partners, Inc. (AHP) in the hospital operated by AHP. The Patients Accounts Team will maintain primary responsibility for maintaining the list of Medicare bad debts and making a reasonable collection effort to collect on those bad debts. All accounts will be handled in an identical manner. Any variations will be specifically noted in the description. Medicare and all other insurances will be handled in the same manner for billing purposes.

**Procedure:**

ADMISSION PROCESS

1. Once the type of insurance is identified at the time of admission, if this insurance is a managed care or commercial carrier then the insurance will be contacted to obtain authorization.
2. If the patient has Medicaid a Verification of Eligibility needs to be done and placed in the patient chart.
3. It will be determined the level of benefits that are available for the contemplated service. If the patient does not have mental health benefits or has exhausted their benefits, the patient will be considered self-pay and the applicable policy will be applied (see self-pay below).
4. If the patient has a deductible or coinsurance amount that will be applied for the service, we will request payment before services are rendered if it is medically/clinically appropriate to attempt to do so based on the patient's level of acuity.
5. If Services appear to be a non-covered benefit, then an Advance Beneficiary Notice will be completed.
6. All insurance cards will be copied (if available)

BILLING PROCESS

1. When the patient has been discharged the completed billing form will be sent to the appropriate insurance carrier including Medicare and Medicaid managed care for processing.
2. If the carrier makes payment for less that the contractual/agreed upon amount then the nature of the short payment will be determined.
    a. If there has been a rejection because of Lack of Authorization, Continued Stay Authorization or Non-Medical Necessity, the appropriate appeal process will be implemented.
    b. If the claim has been denied because the patient's insurance plan does not cover the service in question the account is to be transferred to self-pay (see SELF PAY below). If the patient has Medicare coverage as primary the ABN must have been signed in order for the patient to be billed.
    c. If the patient has another insurance plan or a secondary plan, that insurance must be billed for a determination.
    d. If the claim is not paid/or only partially paid as the benefits have been exhausted, the account is to be transferred to Self-Pay and the patient billed for the applicable amount if an ABN has been signed (see SELF PAY below).If the insurance carrier applies different deductibles/co insurance from what we had been originally advised, the patient is to be billed for these amounts less any payments previously made. The account is then to be moved to the self-pay category (see SELF PAY below).
    e. A statement of hospital services is sent to the patient/guarantor monthly. In cases where the client has no insurance coverage (self-pay) the statement is sent after services are provided. In most cases clients have coverage through an insurance company. In this case the statement is sent after the services have been provided, and the claim has been submitted/adjudicated by the insurance company.
    f. Monthly statements sent include information on the AHP's available financial assistance and assigned account representative and contact phone number. AHP will accept financial assistance applications for a minimum of 240 days from the date of the first post-discharge billing statement.

COLLECTION PROCESS

Once all payments are received and the account balance has been determined to be accurate as to the patient responsibility the collection process begins. All patients who are included in the SELF-PAY PROCESS will receive the same number of statements to collect the outstanding balance. This process will include a minimum of three (3) statements and collection effort of at least 120 days after the first bill is sent to the patient requesting payment.

1. If the patient had Medicare and it is verified active the account is written off to bad debt and no letters are sent to the patient.
2. First statement is sent to the patient.
3. Second statement is sent to the patient.
4. Third statement is sent to the patient
5. A follow-up phone call may be made to the patient requesting payment on the account.
6. Once the third statement is sent the accounts are to be reviewed to make sure all statements have been mailed and that no addition payments have been received. If a payment is made the self-pay collection efforts starts again. Once this is verified the account will be written off to bad debt.
7. Collection efforts are documented on the clients account in the electronic billing system.
8. It is the policy of AHP not to engage in extraordinary collection actions (ECAs) against a client to obtain payment for care before making reasonable efforts to determine whether the client is eligible for assistance under its financial assistance policy. ECAs may include turning collections over to an outside collection agency after the later of 120 days or four statement cycles from date of the first post discharge statement. Written notice will be provided to the client thirty days in advance of any ECA. If the financial assistance application is received during the 240-day application period, any ECA initiated will be suspended.
9. Clients who are eligible for financial assistance will not be charged more for medically necessary care than amounts generally billed (AGB) to insured clients. AHP uses prospective Medicare fee-for-service method for determining AGB.

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**Attachments:** None

| **Authority:** | **Date:** |
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| **Linda Damm (CFO)** | **05/19/2023** |
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