Policy

Patient Financial Services Billing & Collection Policy

Purpose:

This policy describes Osceola Medical Center's (hereafter to be referred to as "OMC")patient billing process and collection actions which may be taken in the event of nonpayment for medical care provided by OMC such as extraordinary collection actions. The guiding principles behind this policy are to treat all patients and responsible guarantors (hereafter to be referred to as "patient(s)" equally with dignity and respect, to ensure appropriate billing and collection procedures are uniformly followed, and to endure that reasonable efforts are made to determine whether the patient is eligible for assistance under Osceola Medical Center's Financial Assistance Policy (hereafter to be referred to as "FAP").

Policy Statement:

After our patients have received services, it is the policy of OMC to bill patients and their applicable payers on a timely and accurate basis. During this billing and collection process, OMC staff will be committed to providing quality customer service and timely follow up on all outstanding accounts. OMC staff will also maintain alertness for factors which may indicate a patient is a candidate for financial assistance under the FAP and assist patients with that process.

Definitions:

- Plain Language Summary means a written statement that notifies an individual that Osceola Medical Center offers financial assistance under the FAP for inpatient and outpatient hospital services and contains the information required to be included in such statement under the FAP.
- Application Period means the period during which Osceola Medical Center must accept and process an application for financial assistance under the FAP. The Application Period begin on the date the care is provided and ends on the 24th day after the PH provides the first billing statement.
- Billing Deadline means the date after which Osceola Medical Center may initiate an ECA against a Responsible Individual who has failed to submit an application for financial assistance under the FAP. The Billing Deadline must be specified in a written notice to the Responsible Individual provided at least 30 days prior to such deadline, but no earlier than the last day of the Notification Period.
- Completion Deadline means the date after which Osceola Medical Center may initiate or resume an ECA against an individual who has submitted an incomplete FAP if that individual has not provided the missing information and/or documentation necessary to complete the application. The completion Deadline must be specified in a written notice and must be no earlier than the later of (1) 30 days after Osceola Medical Center provides the individual with this notice; or (2) the last day of the Application Period.
- Extraordinary Collection Action (ECA) means any action against an individual responsible for a bill related to obtaining payment of a Self-Pay Account to another party for purposes of collection without the use of any ECAs. FAP-Eligible Individual means a Responsible Individual

eligible for financial assistance under the FAP without regard to whether the individual has applied for assistance.
    - Selling a patient's debt to another party in most circumstances
    - Reporting adverse credit information regarding a patient to a credit agency.
    - Deferring or denying current medically necessary care due to an unpaid prior account or requiring payment of an unpaid prior account prior to rendering current medically necessary care.
    - Actions that require a legal or judicial process: including property liens, wage garnishments, bank account garnishments or holds, commencing a civil action, and other specified legal actions.
- Financial Assistance Policy (FAP) means Osceola Medical Center Financial Assistance Program for Uninsured Patients Policy, which includes eligibility criteria, the basis for calculating charges, the method for applying the policy and the measures to publicize the policy, and sets for the financial assistance program.
- Notification Period means the period during which Osceola Medical Center must notify an individual about its FAP in order to have made reasonable efforts to determine whether the individual is FAP-Eligible. The Notification Period begins on the first date care is provided to the individual and ends on the 120th day after PH provides the individual with the first billing statement for the care.
- PFS means Patient Financial Services, the operating unit of Osceola Medical Center responsible for billing and collecting Self-Pay Accounts.
- Responsible Individual means the patient and any other individual having financial responsibility for a Self-Pay Account. There may be more than on Responsible Individual.
- Self-Pay Account means the portion of a patient account that is the individual responsibility of the patient or other Responsible Individual, net of the application of payments made by any available healthcare insurance or other third-party payer (including co-payments, co-insurance and deductibles), and net of any reduction or write off made with respect to such patient account after application of an Assistance Program, as applicable.
- Medically necessary care is the care that, in the opinion of the OMC credentialed treating physician/clinician and according to standard of care, is reasonably needed:
    - To prevent the onset or worsening of an illness, condition, or disability;
    - To establish a diagnosis;
    - To provide palliative, curative or restorative treatment for physical, behavioral and/or mental health conditions; and/or
    - To assist the individual to achieve or maintain functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.
    - Medically necessary services include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act, and any inpatient or outpatient hospital service that is covered by and considered to be medically necessary under Title XVIII of the Federal Social Security Act. In addition, care provided in the hospital facility by a partnership or LLC in which the hospital owns a capital or profits interest is eligible for financial aid. Services must be performed in accordance with national standards of

medical practice generally accepted at the time the services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
    - Medically necessary services do not included services that are experimental interventions or cosmetic in nature.
    - Other conditions supporting medical necessity of particular treatments include:
        - High quality scientific evidence that patients with this particular condition will benefit from the requested treatment
        - The type of benefit is clinically significant ; and/or
        - Less costly alternative treatments and routes of administration have been considered and rejected.
- Fiscally Unsustainable Burden means a situation where there is a significant cost to an OMC tax-exempt entity to provide the service and the incidence of potential patient need for the services is such that the entity could not provide the same service without adequate reimbursement to all similarly situated patients and remain fiscally responsible.
- Family, for the purposes of this policy, a family is:
    - A married couple and any dependents, as defined by IRS guidelines
    - An individual with dependents as defined by IRS guidelines
    - An unmarried person with no dependents
    - Poverty guidelines will be applied separately to each family within a household if the household includes more than one family unit.

Policy/Procedure:

Patient Billing

It is the goal of OMC to bill all insurance claims accurately and on a timely basis. Although dependent on information and communication from patients and payers, OMC will provide sufficient follow up service to ensure that patients receive accurate account and billing information and have the opportunity to make payment and/or apply for Community Care. The billing process will be assisted by the following guidelines:

A. For all insured patients, OMC will bill all third-party payers (as provided by or verified by the patient) on a timely basis, with the following exception:
    a. Out of country insurance – The patient is provided with a copy of the bill to submit to their insurance at patient's request. OMC expects payment from the patient within 90 days. OMC may, at its sole discretion, on a case-by-case basis choose to bill out of country insurance as a courtesy to the patient.
B. In accordance with OMC's current Attorney General Collection Standards Agreements, all uninsured patients with Wisconsin or Minnesota residency who receive medically necessary hospital-based services will receive an uninsured discount. The uninsured discount will be equal to the discount provided to our largest contracted non-government payer and any remaining balance will be billed to the patient in a timely manner as part of OMC's normal billing process. All patients may request an itemized statement for their accounts at any time.
C. If a claim is denied (or is not processed) by a payer due to OMC error, OMC will not bill the patient for any amount in excess of that for which the patient would have been liable had the payer paid the claim.

D. If a claim is denied (or is not processed) by a payer due to factors outside of OMC's control, OMC staff will follow up with the payer and patient as appropriate to facilitate the resolution of the claim. If resolution of the claim does not occur after reasonable follow-up efforts, OMC may bill the patient or take other actions consistent with current OMC best practice standards.
E. All billed patients will have the opportunity to contact OMC regarding financial assistance or discuss a payment arrangement for their accounts at any time in the billing process.

Patient Collections and Agency Collections:

A. At least 3 separate statements for collection of self-pay accounts shall be mailed or emailed to the last known address of each patient; provided, however, no additional statements need to be sent after a patient submits a complete application for financial assistance under the FAP or has paid-in-full. At least 60 days shall have elapsed between the first and last of the required 3 mailings. It is the patient's obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, staff will determine if alternate methods for locating the patient are available. All single patient account statements of self-pay accounts will include but not limited to:
    a. An accurate summary of the services covered by the statement-initial statement only
    b. A written notice that notifies and informs the patients about the availability of financial assistance under the hospital FAP, including the telephone number of the department and direct website address where copies of documents may be obtained.
B. At least one of the statements sent during the Notification Period will include written notice that informs the Responsible Party about the ECAs that may be taken if the Responsible Individual does not apply for financial assistance under the FAP or pay the amount due by the Billing Deadline (i.e., the last day of the Notification Period). Such a statement must be provided to the Responsible Individual as least 30 days before the deadline specified in the statement.
C. If a patient disputes his/her account and/or requests documentation regarding the bill, OMC will provide the requested documentation in writing within 10 days. If a 10 day response is not possible, an acknowledgement letter will be sent within 10 days and the account will remain on hold for 30 days before continuing further collection past the date the response was sent in. The foregoing response standards shall also apply to OMC's collection agencies and collection attorneys.
D. Patient care concerns will be handled via the patient grievance process for resolutions and response to the patient. Accounts(s) will be held as appropriate.
E. Through the use of billing statements, letters and phone calls, OMC will take diligent follow up actions to contact patients to resolve outstanding accounts, including maintaining alertness to potential patient eligibility for Community Care. Detailed itemization of OMC charges will be provided upon request. It is the responsible individual's obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination of "Reasonable Effort" will have been made. If accounts are not resolved during this process, the outstanding balances may be referred to their-party agency or attorney for collection.

Legal Collections and Extraordinary Collection Actions:

A. Subject to compliance with the provisions of this policy, OMC may place accounts with legal collections and take any and all legal actions, including ECAs, to obtain payment for medical services provided.
B. Extraordinary Collection Actions may be commenced as follows:
    a. A minimum of 120 days will be provided from the patient's first post-service bill before ECAs will be taken and OMC shall also provide a minimum of 240 days from that statement date for the patient to apply for Community Care under the FAP.
    b. If a patient has applied for Community Care under the FAP prior to the start of legal collections, OMC shall make a determination of the patient's eligibility before ECAs are commenced. If the patient already has a previous Community Care determination within the last six months, this prior determination will be used unless the patient's circumstances have materially changed to warrant new consideration.
    c. Prior to placing accounts with legal collection, OMC will perform a Community Care indicator screening to determine if any accounts should be withheld from legal collections. For accounts placed with legal collections, OMC shall first provide a written notice to the patient that ECAs are intended. This notice shall include a plain language summary of the FAP and shall be provided at 30 days prior to ECAs being commenced. During this 30-day window, OMC shall also use reasonable efforts to verbally notify the patient that ECAs are intended and to notify the patient about Osceola Medical Center's Financial Assistance Policy. An example of reasonable efforts for this verbal notice includes calling the patient and leaving a voicemail for a return call.
    d. After the commencement of ECAs is permitted, external collection agencies shall be authorized to report unpaid accounts to credit agencies, and placement with legal collections, the collection attorneys shall be authorized to conduct ECAs such as filing judicial actions, carrying out wage an bank garnishments, and using other lawful means of collection; provided, however, that prior approval of Patient Financial Services shall be required before initial lawsuits may be initiated. Such activities shall occur under the requirements of OMC's Attorney General Collection Standards Agreements as outlined in the contracts between parties.
    e. If a patient submits a Community Care application in good faith while ECAs are in progress, OMC will use best efforts to hold ECAs while the application is processed, and final determination made.

Customer Service:

During the billing and collection process, OMC and its agents will provide quality customer service by implementing the following guidelines:

- OMC and its agents will enforce a zero-tolerance standard for abusive, harassing, offensive, deceptive or misleading language or conduct by its employees.
- OMC and its agents will maintain a streamlined process for patient questions and/or disputes which includes a toll-free phone number patients may call and a prominent business office address to which they may write. This information will remain listed on all patient bills and collection statements sent by OMC.

- After receiving a communication from a patient, OMC and its agent's staff will return phone calls to patients as promptly as possible (but no more than 3 business days after the call was received) and will respond to written disputes within 7 days per the complaint grievance process.
- OMC and its agents will maintain a log of patient complaints and grievances (oral or written)

Policy Availability:

- Electronic copies of the OMC Billing and Collection Policy, OMC Financial Assistance Policy and our Community Care Application form can be found on our **website: wwwmyomc.org**
- You can also contact our Business Office to request copies of policies be mailed to you or discuss the Community Care application and eligibility process at 715-294-5637
- Paper copies of our policies and Community Care application form can be obtained from our Financial Counseling Office
    - 2600 65th Avenue, Osceola, WI 54020