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| https://harlancountyhealth.com/wp-content/uploads/2019/07/Harlan-County-Logo-2.png | **Patient Financial Policy** |
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| **Policies and Procedures** |
| **Department:** Finance, Registration |
| **Created:** 4/29/2022 | **Approved On:** July 18, 2022 | **Next Review:** { Next Periodic Review Date } |

**PURPOSE:**

To set clear expectations regarding patient financial responsibility for services provided to the patients of Harlan County Health System

**APPLICABILITY:**

* Harlan County Health System
* Harlan County Health System – Alma Clinic
* Harlan County Health System – Oxford Clinic

**DEFINITIONS:**

**POLICY:**

The financial responsibility for patient care belongs to the patient (guarantor). The following guidelines should be followed during the collection process to insure fair, non-discriminating collection procedures on all outstanding accounts. For all medically necessary care, the patient has the right to be screened for financial assistance. Please see the Charity Care Policy for further guidance.

**PROCEDURE:**

1. All accounts are due and payable at the time of service. If verified insurance information is not provided, the patient will be treated as self-pay. Please reference the appropriate Charity Care policy.
2. Patients with Health Insurance Coverage
	1. Patients are required to provide current regulatory (Medicare and Medicaid) insurance coverage information prior to or at the time of service.
	2. It is the patient's responsibility to verify that their provider is participating with their insurance carrier.
	3. Deductibles, copayments, coinsurance based on the estimate are due at or before the time of the patient visit, if applicable; if the patient fails to bring their required copayment to the visit, the visit may be rescheduled (EMTALA regulations apply).
	4. Patients who request services that are not medically necessary, as determined by their physician, will be asked to sign one of the following forms based on insurance type;
		1. Non-Governmental Payers – Advance Beneficiary Notice of Noncoverage
		2. Medicare - Advanced Beneficiary Notice (ABN). Payment upfront for service may not be required as there is the option to bill Medicare
		3. Medicaid – Advanced Beneficiary Notice (ABN). Payment upfront for service not required as there is the option to bill Medicaid
	5. If a patient has non-governmental coverage (Medicare, Medicaid, and TriCare excluded) and is electing not to use it, the patient must sign the Waiver of Insurance Benefits form (Attachment E:.) stating that they are electing for HCHS to not bill their insurance. In this case, the patient will be considered self-pay for the applicable encounter and will fall under the Uninsured Discount Policy that applies to their facility or clinic. If the patient fails to sign this document, active insurance will be billed.
	6. When an insurance payment is received and a patient balance is due, the patient (guarantor) is billed for the balance; payment of the balance is expected within 30 days from receiving the first statement or an acceptable payment arrangement with HCHS must be made. See Payment Plan Guidelines ·{HCHS)
	7. If the patient is injured in a motor vehicle accident the following filing order should apply based on medical coverage:
		1. Commercial Insurance - patient's auto carrier, commercial insurance secondary, then second driver's auto carrier
		2. Regulatory Insurance - patient's auto carrier, second drivers auto carrier, regulatory Insurance (Medicare, Tricare)
		3. Medicaid Only- patient's auto carrier, Medicaid
		4. Accounts with no insurance - patient's auto carrier, second driver's auto carrier, Self• Pay/Medicaid Pending
	8. HCHS will provide an itemized statement, upon the patient’s request, that can be used to file with the patient's insurance carrier.
	9. Acceptable payment methods include cash, check, bank debit cards, money order, Visa, MasterCard, American Express, traveler's check, cashier's check, and Discover cards.
	10. If an insurance carrier denies a claim, the balance may be the patient's responsibility.
	11. If secondary insurance coverage is available, any remaining balance after the primary insurance will be billed to the secondary carrier.
		1. Physician Billing - If no payment is received after 45 days from the secondary carrier bill date, and the secondary carrier is not Medicare, Medicaid or Work Comp, the balance will become Self-Pay.
		2. Hospital Billing- If no payment is received after 45 days from the secondary carrier bill date, the balance will not be dropped to self-pay until the billing follow-up team has reviewed the secondary balance as appropriate to be moved as patient responsibility, or we reviewed a payment from the payer moving the balance to patient responsibility.
	12. Worker's Compensation
		1. To file Worker's Compensation, the patient must comply with all Worker's Compensation requirements; this includes, but is not limited to:
			* 1. Notifying the patient's employer prior to the service.
				2. Preauthorizing all services related to the work injury prior to seeing the physician.
				3. If HCHS is unable to get information about the authorization, the patient may be rescheduled until authorization is obtained. This does not apply to emergent cases.
3. Patients without Health Insurance Coverage
	1. A minimum payment is required at the time of service, regardless of the level of financial assistance. The minimum payment for an office visit is $50.
		1. If a patient without health insurance is unable to afford the minimum amount due, the patient needs to be referred to a financial counselor or an appropriate resource to be screened per the Charity Care policy
	2. For physician fees relating to Inpatient and Outpatient hospital services (e.g., surgery), not covered under HCHS providers, it is the patient's responsibility to make payment arrangements at or before the time of service.
4. Collections
	* + 1. When the appointment is scheduled or pre-registered, patients should be notified of the patient responsibility (copay, deductible, coinsurance, etc.). Unpaid balances are due at the time-of­service or the patient must make a specified prepayment to establish a payment plan.
			2. The Day of Service
				1. Prepayment patient responsibility for current date of service is due and is expected to be collected at or before the time of service at check in/registration for all scheduled services.

If the patient does not have the funds available for payment, their appointment may be rescheduled at the discretion of the attending clinician or facility. For inpatients, it is acceptable to collect the minimum payment and/or establish a payment plan during the stay or at the time of discharge. For patients in the Emergency Department, it is acceptable to collect the minimum payments and/or establish a payment plan after a qualified medical provider determines whether an emergency medical condition exists.

* + - * 1. If the patient has an outstanding balance with HCHS (facility or clinic), payment is requested in full prior to being seen for the current service (at check-in).
1. If they do not have the funds available for payment, they will be asked to contact the Business Office to make payment arrangements and begin making payments.
2. If no arrangement is made, their appointment may be rescheduled to a future date, depending on the medical urgency of the visit.
	* + 1. After the charges are entered for self-pay patients or payment is received from a third party, the encounter is sent to the self-pay agency and a billing statement is generated and sent to the patient (guarantor) or responsible party for their balance; a note on the statement indicates that payment is now due.
			2. The patient (guarantor) has 180 days from date of placement with the self-pay agency to respond and pay or set up a payment plan. Failure to do this will result in the date of service being turned over to a bad debt collection agency.
				1. Once an account has been moved to bad debt, hospitals and clinics should not collect on those accounts as there could be pending litigation with the collection agency.
3. Statements- The following outlines the minimum number and frequency of statements distributed to each patient based on the self-pay balance on the account:

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| Statement #1 | 30 Days After Balance becomes Patient Responsibility |
| Statement #2 | 60 Days After Balance becomes Patient Responsibility |
| Statement #3 | 90 Days After Balance becomes Patient Responsibility |
| Final Demand Letter | 120 Days After Balance becomes Patient Responsibility |