Granville Health System	Manual: Administrative			
Subject **Financial Billing Policy**	**Number:** **F-225**	**Revised:** **03/14/18** **01/21/19** **01/08/20** **02/03/21** **01/14/22**	**Effective Date:** **9/29/14**	**Page** **1 of 8**
Distribution **All Departments**	**Supersedes:** **All Previous**	**Prepared By:** **Administration**	**Approved by:** **Board of Trustees / Finance Committee**	

FINANCIAL BILLING POLICY

Granville Health System is a not-for profit hospital committed to providing quality health care services to our patients. In order to provide necessary medical services to our community, GHS must maintain a strong financial foundation that includes the timely collection of all Accounts Receivable. This policy establishes GHS financial requirements for payment of services based on consistent compliance criteria incorporating individual patient financial conditions and circumstances. This policy will ensure the appropriate resolution of patient financial obligations to GHS while maintaining optimal customer satisfaction. As a not-for profit hospital, GHS is committed to providing medically necessary services to all patients regardless of their ability to pay. Medical Necessity may be determined by certain payors resulting in patient responsibility for account balances.

POLICY

GENERAL REQUIREMENTS: Patients with the ability to pay are expected to pay for their health care, including the requested co-pay, any coinsurance, deductible, and for some services a deposit, which will be due and payable at the time of service. Patients without the ability to pay for some or all their care will be expected to verify their financial status with a GHS financial partner that provides credit-based options or noncredit based repositioning plans. Patients that do not qualify for credit based or noncredit based repositioning plans or do not agree with the determination made by the financial partner, may request evaluation by Medicaid and/or Medical Financial Assistance. Failure to cooperate could result in the postponement or cancellation of non-emergent/non-urgent care. All communication with patients concerning their financial responsibilities will be handled with empathy, care and concern.

1. Urgent is defined as a condition which, if treatment is delayed may lead to increased risk of death, hospitalization, permanent disability or a need for emergent care.
2. Emergent is defined as a condition for which the necessity of immediate health care treatment is so reasonably apparent that any delay in rendering the treatment would seriously worsen the physical condition or endanger the life of the person.

SCHEDULING: At the time of pre-registration, the patient will be informed of payment expectations, dependent upon third party payer or self-pay guidelines. At that time, the patient will be informed that if payment expectations cannot be met, the patient will be referred to the GHS financial partner for credit based and/or noncredit based repositioning plans. Patients that do not qualify for credit based or noncredit based repositioning plans or do not agree with the determination made by the financial partner, may request evaluation by Medicaid and/or Medical Financial Assistance.

REGISTRATION/CHECK IN: The patient will be asked to pay any amounts due for prior balances, any co-pays and coinsurances due for current services. Patients that request to be billed for co-pays, coinsurances, and/or deductibles may be granted an exception if there are no outstanding balances on their accounts and the amount due is less than $1,000. Some services may require deposits towards future scheduled services. If the patient cannot or will not comply with the request for payment, the patient may be referred to a GHS financial partner for credit based and/or noncredit based repositioning plans. Patients that do not qualify for credit based or noncredit based repositioning plans or do not agree with the determination made by the financial partner, may request evaluation by Medicaid and/or Medical Financial Assistance. If the visit or service is not of an urgent/emergent nature, or the first consequent follow-up visit from the Emergency Department, the attending physician will be notified for possible postponement of service.

NON-EMERGENCY SCHEDULED PATIENTS: Patients are expected to resolve their identified financial obligations to GHS prior to their scheduled date and time of service. GHS expects cash or credit card pre-payments prior to the scheduled date of service or at the time of service. If payment expectations are not met, rescheduling of service may occur. Patients that request to be billed for out of pocket expenses may be granted an exception if there are no outstanding balances on their accounts and the amount due is less than $1,000. Patients may be referred to a GHS financial partner for credit based or noncredit based repositioning plans. Patients that do not qualify for credit based or noncredit based repositioning plans or do not agree with the determination made by the financial partner, may request evaluation by Medicaid and/or Medical Financial Assistance.

NON-EMERGENCY UNSCHEDULED PATIENTS: Patients are expected to resolve their identified financial obligations to GHS at the time of service. If payment expectations are not met, rescheduling of service may occur. Patients that request to be billed for out of pocket expenses may be granted an exception if there are no outstanding balances on their accounts and the amount due is less than $1,000. Patients may be referred to a GHS financial partner for credit based or noncredit based repositioning plans. Patients that do not qualify for credit based or noncredit based repositioning plans or do not agree with the determination made by the financial partner, may request evaluation by Medicaid and/or Medical Financial Assistance.

PATIENTS SEEKING EMERGENCY CARE AND URGENT PATIENTS: GHS will provide emergency services regardless of the patient's ability to pay for those services consistent with our organizational mission and in compliance with applicable Federal and State regulations. Only after the medical screening examination has been completed, will GHS staff discuss any financial obligations with the patient. The patient will be asked to pay the out of pocket amount that is applicable based on insurance coverage or, if they are self-pay, the patient will be asked to pay a $50.00 deposit. Patients may be referred to a GHS financial partner for credit based or noncredit based repositioning plans. Patients that do not qualify for credit based or noncredit based repositioning plans or do not agree with the determination made by the financial partner, may request evaluation by Medicaid and/or Medical Financial Assistance.

ESTIMATE OF CHARGES: Any patient may obtain an estimation of charges and/or financial liability amounts after insurance by contacting the Admissions Department at 919-690-2142 or 919-690-3204. Estimation documentation will be provided to the patient within three business days from the date of request. A listing of current hospital charges and the most common charges for inpatient admissions are listed on the GHS website under Pricing Transparency. Estimate information is not a guarantee of final patient financial responsibility and the bill received may reflect a different amount from the original estimate due to the complexity of factors that go into hospital billing.

PROCESSING OF FINANCIAL LIABILITY: The person who is financially responsible for the patient's bill is considered the Guarantor. In the case of an adult, the patient is his/her own guarantor. Children under the age of 18 cannot be listed as their own guarantor unless they are emancipated. The responsible party will be the guardian of the minor that signs the facility consent for treatment authorization form at the time of treatment. If the person presenting the child for treatment is someone other than a parent/guardian (i.e. babysitter, grandparent, neighbor, etc.), the legal guardian of the patient will be contracted via phone by Admissions staff to obtain verbal authorization for treatment. The guardian providing the verbal authorization will be listed as the guarantor and will be financially responsible.

Processing Guidelines:

A. NON-MEDICALLY NECESSARY CARE: GHS will complete Medical Necessity reviews on patients as follows:

1. Non-surgical Medicare outpatients - For services that are determined "not medically necessary" according to Medicare's LMRP criteria, an Advanced Beneficiary Notice (ABN) will be generated and the patient will be asked to sign the form agreeing to be personally and fully responsible for the payment. Claims will be completed and submitted according to CMS billing guidelines. Patient liability balances where an ABN is signed and on file will be processed according to self-pay guidelines. Patients will be prompted for payment at the time of service. Patients may be referred to a GHS financial partner for credit based or noncredit based repositioning plans. Patients that do not qualify for credit based or noncredit based repositioning plans or do not agree with the determination made by the financial partner, may request evaluation by Medicaid and/or Medical Financial Assistance. If payment expectations are not met, rescheduling of service may occur.

2. Inpatients, SDS, ER patients, Observation patients & extended recovery patients - When a medical necessity issue is identified, clinical staff will coordinate resolution, as appropriate, with the physician, Care Management, Patient Access staff and Patient Financial Services Team. If the ordering physician disagrees with the Administrative or clinical review and requirements, an assessment will be conducted by the Chief of Surgery to determine medical necessity. The Chief of Surgery's clinical review will include, but not be limited to the scheduling package [orders, consent, history and physical, etc.]. The Chief of Surgery will consider physician to physician communications in forming his/her recommendation. The Chief of Surgery's decision will be considered final and communicated directly to the ordering physician and the Director of Surgery within four hours.

B. PATIENTS WITH VALID INSURANCE COVERAGE: GHS will complete and process all identified insurance claim submission activities for billing and payment according to the following guidelines providing valid insurance coverage is identified:

1. Insurance will be accepted as satisfying a patient's requirement for financial resolution as part of comprehensive processing when all required insurance data set information has been collected/validated/updated and coverage is verified. Insurance accounts with anticipated deductibles, co-payments, co-insurances and/or non-covered charges will be screened and processed as follows:

   a. Insurance accounts with deductibles, co-payments, co-insurances and non-covered charges identified during pre-service or time of service will be flagged for financial resolution of these balances prior to services rendered and no later than the time of discharge. Patients that request to be billed for their out of pocket expenses may be granted an exception if there are no outstanding balances on his/her accounts and the amount due is less than $1,000. Patients may be referred to a GHS financial partner for credit based or noncredit based repositioning plans. Patients that do not qualify for credit based or noncredit based repositioning plans or do not agree with the determination made by the financial partner, may request evaluation for Medical Financial Assistance. Based on Administrative or clinical review or subsequent review by the Chief of Surgery, services may be delayed or canceled as appropriate, pending pre-service and/or time of service payment to create financial resolution. For Emergency Department, Observation and Inpatients, the identified patient liabilities will be requested prior to discharge from the facility.

b. Insurance accounts where patient liabilities cannot be identified until after insurance processing will become a patient liability and will be processed according to patient liability billing and follow-up guidelines below. For accounts meeting threshold guidelines and when patient liability cannot be established during insurance processing, a down payment may be requested in the amount of up to $100.00.

c. Insurance accounts with identified patient liabilities are required to be financially resolved using the payment options below no later than the day of discharge. Patients with self-pay balances for an inpatient admission may be referred to a GHS financial partner for credit based or noncredit based repositioning plans. Patients that do not qualify for credit based or noncredit based repositioning plans or do not agree with the determination made by the financial partner, may request evaluation by Medicaid and/or Medical Financial Assistance. Based on clinical review, additional services may be delayed or canceled, as appropriate, pending pre-service or time of service financial resolution. Payment Options may include but not be limited to:
   - CASH PAYMENTS: Accept cash, money orders or checks for payment
   - CREDIT CARDS: Accept VISA, MasterCard, or Debit Card
   - Credit based financing options and noncredit based repositioning plans established through partnerships with Granville Health System.
   - PAYMENT PLANS: GHS offers payment plans based on financial documentation, according to approved departmental guidelines. ***Minimum monthly payment amount is $50.00.***
   - FINANCIAL ASSISTANCE (Medical Financial Assistance): GHS encourages patients to apply for financial assistance and will screen patients according to eligibility rules as defined in governmental assistance program guidelines and/or GHS Medical Financial Assistance program.
   - OTHER FUNDING: GHS may assist with other funding programs for those patients that exceed Government guidelines for Medical Financial Assistance but have other qualifying circumstances that may warrant financial assistance.

d. Under threshold patients will be subject to billing statement and the hospital collection policy.

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e. Where contracts prohibit GHS from pursuing open insurance liabilities from the patient, Patient Financial Services will continue to pursue payment with the third-party payer until payment is received according to established follow-up policy and procedure.

f. For contracted payers where a pattern of payment delays has been determined by Patient Financial Services, the issue will be referred to Management. Revenue Cycle Management will work with the third-party payer to resolve the issue.

g. GHS reserves the right to contact the insured's employer to assist in the verification of insurance coverage.

h. For services that have been deemed Medically Necessary through appropriate protocols, Patient Representatives will notify the patient of their total liability resulting from co-pays, co-insurances and/or deductibles upfront prior to or on the date of service. Patients may be referred to a GHS financial partner for credit based or noncredit based repositioning plans. Patients that do not qualify for credit based or noncredit based repositioning plans or do not agree with the determination made by the financial partner, may request evaluation for Medicaid and/or Medical Financial Assistance. If the patient is unable to make payment in full upfront or qualify for Medicaid or Medical Financial Assistance, representatives will reduce the requested upfront payment amount in $250 increments for balances greater than $500. Balances

of $500 or less will be reduced in increments of $100. This tactic will apply to upfront out-of-pocket payments that are being requested prior to or on the date of service only and will not reduce the balance of the true patient responsibility.

i. The following Deposits/Advance payment schedules are expected at a minimum. Approval by the Director of Patient Financial Services or Director of Patient Access is required for those patients that are unable to meet these payment levels:

Medicare Co-Pays/Deductibles	50%
Commercial Co-Pays/Deductibles	50%
Self-Pay No Insurance	70%

GHS Balance Payment Arrangements

Amount Due	Monthly Payment Amount	Allowable Terms
$1.00-$50.00	Payment in Full	30 days
$51.00-$150.00	1/2 of amount due	30 days
$151.00-$300.00	1/3rd of amount due	90 days
$301.00-$750.00	1/6th of amount due	6 Months
$751.00 to $2000.00	1/12th of amount due	12 Months
Over $2000.00	1/18th of amount due	18 Months

If patient cannot meet these payment arrangements, the final arrangements must be approved by the Director of Patient Financial Services or Director of Patient Access.

C. PATIENTS IDENTIFIED AS SELF PAY: When the patient has no insurance coverage, the account will be documented as the responsibility of the patient/guarantor and processed according to the following guidelines:

1. All patients identified as self-pay with balances greater than $750.00 or a combined total of $750.00 and above established thresholds will be screened for Medicaid eligibility or Medical Financial Assistance.

   a. Accounts will be evaluated for Medicaid coverage using established Medicaid screening criteria and will also be evaluated for possible Medical Financial Assistance

   b. Medical Financial Assistance qualification according to established eligibility rules as defined in the GHS Medical Financial Assistance Policy

   c. Accounts will be referred for Medicaid processing as follows:
      - Patient Financial Services/Patient Access Counselor will complete financial education with self-pay or underinsured patients. Payment will be requested prior to services or a monthly payment contract will be established for the balance of the account.
      - Patients who are believed to meet Medicaid guidelines will be interviewed by our Medicaid eligibility staff or referred to their local county Department of Health and Human Services office to complete an application for Medicaid.
      - Accounts meeting possible qualification criteria are updated in the system as Pending Medicaid and remain there until approval or denial information is received.
      - Accounts that do not meet qualification criteria remain as self-pay and are processed according to self-pay processing criteria.

d. Self-Pay OB patients should be screened prior to the delivery of the newborn. This process will begin when the local OB offices or Health Departments refer patients to GHS to discuss financial obligations and resolve them prior to delivery.

e. Newborns – Accounts meeting possible qualification criteria are updated in the system as Medicaid eligibility staff reviewing for Medicaid coverage and remain there until approval or denial information is received. The Newborn account is billed as a Self-Pay until the baby is approved for Medicaid coverage.

2. Remaining self-pay accounts will be flagged for financial counseling to ensure that the patient is given a full understanding of their financial liability for their requested service. Financial counseling will be completed at the earliest opportunity prior to service for scheduled patients and at the time of service or no later than discharge for non-scheduled patients including emergency patients who have been stabilized. Financial counseling will assist the patient in the identification of alternative funding sources for financial resolution.

3. Self-Pay Discount Program – Patients who have no third-party coverage (uninsured or uninsurable) are eligible for a 20% self-pay discount.

4. Upon completion of patient financial counseling, patients are required to finalize a mutually acceptable financial agreement with GHS. Self-pay patients will be required to financially resolve their estimated charges using one of the facility approved payment options prior to or on the date of service. Based on clinical review, services may be delayed or canceled, as appropriate, pending pre-service or time of service financial resolution, however, at no time will emergency treatment be delayed due do a patient's inability to pay. Patients who make pre-payments will receive a receipt at the time of payment. Payment plan arrangements will be documented in the registration/billing system or referred to the Patient Financial Services area for additional financial counseling.

D. PATIENT LIABILITY BILLING AND FOLLOW-UP: Patient liability billing and follow-up will be completed on all accounts in the self-pay and self-pay after insurance categories. These account balances will be billed to the patient requesting the balance be paid in full.

1. If payment is not remitted in full or a suitable payment plan is not established within 30 days of the initial billing statement, the account will be referred to Professional Recovery Consultants (PRC) as an Early Out, Extended Business Office placement. PRC will retain the outstanding balance for 90 days and will make calls to aid in balance resolution. A series of statements will continue to be sent to the patient from GHS during this timeframe.

2. If the balance of the account is not resolved within the 90 days, the account will be sent a NC Debt Offset notice letter for balances greater than $50.00. This letter outlines all possible options for collections of the account that may occur if the bill is not paid (i.e. liens, judgements, credit reporting, and/or garnishment). The patient will be given 30 days to contest the Debt Offset or to resolve the outstanding balance prior to the debt being submitted for garnishment or being sent to a collection agency for processing. If the account is not resolved, the balance will be referred to the state of North Carolina for Debt Offset in the form of NC Tax Refund and Lottery Winnings garnishment. In addition, the outstanding account will be placed at an external full-service debt collection agency and will be credit reported to the major credit reporting agencies.

a. All outstanding accounts in PRC EBO with balances less than $50.00 will be returned to GHS as bad debt. The process outlined below for Medicare covered patients that do not pay their out of pocket expenses will be followed to file these small balance accounts for Medicare Bad Debt.

b. All accounts placed at the debt collection agency are transferred to a bad debt status and the reserve forbad debt is charged.
c. Prior to any collections agency or other entity initiating ligation for a debt against a guarantor, written consent must be obtained from GHS to proceed with this action.

3. Once accounts with balances exceeding $50.00 are placed with the debt collection agency, a notice letter of intent to credit file will be mailed to the guarantor (party liable for the outstanding debt). If no resolution is made, the account balance will be credit reported.

    a. Outstanding bills for Granville County EMS are subject to wage garnishment if unpaid.

    b. Unresolved accounts for GHS will remain with the debt collection agency and will reflect on the patient's credit for at least 270 days. Once the 270-day timeframe has passed, the account will be returned to GHS as uncollectible bad debt. The process outlined below for Medicare covered patients that do not pay their out of pocket expenses will be followed to file these balance accounts for Medicare Bad Debt.

        - Self-pay accounts included in a declared bankruptcy will have all collection activities terminated. Bankruptcies will be referred for processing according to the established bankruptcy policy and procedure.

        - Self-pay accounts may be written off in part or in their entirety for administrative reasons related to risk management or public relations according to the administrative adjustment policy and procedure.

        - Medicare covered patients who do not pay identified deductibles and/or co-payments will be treated in accordance to applicable Medicare Bad Debt regulations as defined by Center for Medicare and Medicaid Services (CMS) in the Hospital Insurance Manual (HIM 10) to ensure that appropriate reimbursement is received from Medicare for unpaid bad debts.

        - Credit balances on patient accounts will be processed according to established credit balancing procedures. Patient refunds will not be made if outstanding patient and/or guarantor balances exist on active or bad debt accounts. Credit balances will be applied against active GHS and Granville Health, Inc. patient accounts. Refunds will be issued within 45 days of the patient receiving notice of overpayment.

        - If a request is made by the patient for Medical Financial Assistance, all collection efforts will cease until after a determination is made on patient eligibility for coverage by the program. No collection efforts will resume until the patient has been notified of the status of the Medical Financial Assistance application.

            a. Balances approved for 100% coverage by the Medical Financial Assistance program will be adjusted and resolved at a zero balance.

            b. Balances denied or partially approved for Medical Financial Assistance are the responsibility of the patient. Unpaid portions of these accounts will follow the patient liability billing process outlined above.
                i. At no time will a patient approved for Medical Financial Assistance pay more than the Amount Generally Billed (AGB) to health insurance. **For calendar year 2022, this amount is 36.93% of total billed charges.**

E. PATIENTS REFUSING TO COOPERATE: Patients that refuse to cooperate with Patient Care Financial Counselors, Medicaid application processors or Medical Financial Assistance processors in order to determine payment arrangements, may have services postponed. The attending physician will be notified to determine the feasibility of postponement. If the physician determines that the service may be postponed, the financial counselor will notify the patient. If the patient does not agree to terms of payment plans, the physician will be consulted for postponement of services.

F. POSTING OF CASES: Surgical cases will be posted a minimum of 5 business days prior to the procedure [14 days are preferred]. Posting surgical cases prior to the minimum allows the Department of Surgery adequate time to ensure staff coverage, Health Information Management to review documentation, as well as Patient Access an opportunity to acquire necessary insurance precertification and address patient financial liabilities. Patients that have not made appropriate payment/arrangements will be postponed or canceled. For cases that are canceled or postponed, Patient Access will contact the appropriate physician's office, the Surgery Department Director, Surgical Scheduling and the Surgical Nurse Coordinator.

The following criteria must be met for posting surgical or procedures less than 5 days.

1. No implants required
2. The patient has two forms of insurance
3. The patient is Medicaid

G. DISPUTE OF BILLING: Patients/guarantors wanting to dispute a bill or the remaining balance of a bill may do so by calling Patient Financial Services at 919-690-3254 or by submitting their dispute in writing to GHS, Patient Financial Services, PO Box 947, Oxford, NC 27565. The dispute will be reviewed by the PFS Staff and will be referred to the department director or designee for research and resolution. Billing disputes will be handled in accordance to the Patient Complaints policy.

To obtain free copies of this policy (Financial Billing Policy), a plain language summary outlining Medical Financial Assistance and full documentation of the Medical Financial Assistance policy, the Medical Financial Assistance Application, and the associated instructions, please write to Patient Financial Services at 1010 College Street, Oxford, NC 27565. These polices can be found in the emergency room and admission areas of the main Facility or may be downloaded at http://ghshospital.org. Further information about the Medical Financial Assistance Policy and assistance with the application process are available by phone at 919-690-3254 or in person during normal business hours at Granville Health System, 1010 College Street, Oxford, NC 27565.