| MADISON VALLEY MEDICAL CENTER | POLICY NUMBER: 12.100 |
|---|---|
| Effective Date: 03/27/2024 | SECTION: BizOffice |
| Revision Date: Mar 27, 2024 | SUBJECT: Credit and Collections |
| Review Date: Oct 27, 2026 | Approved By: Billie Jo Rowberry |
| CMS Tags: | |

## Policy:

Madison Valley Medical Center recognizes the need to assure:

1. Madison Valley Medical Center acts as a vehicle for the billing of services to patient's third-party carrier. It is the ultimate financial responsibility of the patient to make payment for services received with the guidelines of the credit and collection policy. When a patient lacks the funds to pay the bill, the patient accounting staff may assist the patient in applying for financial assistance.
2. Madison Valley Medical Center recognizes that patient's financial circumstances may require payment for service over time. The following outlines the terms and timelines acceptable for payment of services.
3. The facility acknowledges that there are members in its service area that cannot pay for services but will not be denied care. The facility will apply appropriate financial assistance guidelines to those patients meeting the outlined criteria. Such patients will receive services with no responsibility for payment or payment at a discounted rate.

## Procedure:

1. All patients shall receive an itemized statement and bill in a timely manner upon discharge from the facility. Statements will be mailed monthly with current information related to the balance of the account.
2. Procedures are established to follow-up and take necessary action on accounts that become delinquent or to deal with the patient who refuses to make arrangements for payment.
3. Patients whom at time of discharge do not have insurance coverage and do not establish payment arrangements at the time can be considered delinquent ninety (90) days from discharge date and may be turned over to pre-collections with an outside agency should they not fall into the financial assistance criteria.
4. Private insurance payers may have ninety (90) days from the billing date to make payment on the patient account. If payment is not received in ten (10) days from the first collection letter or the facility is not advised of additional information required, the account will become a private pay account and the credit and collections policy applies.
5. Payment in full or payment arrangements are required for elective services or procedures that are not covered by third parties. Only when necessary, this arrangement can be modified at the discretion of the Revenue Cycle Manager.
6. For Emergency admissions, the facility will admit and render emergency medical services to patients regardless of their ability to pay. The admitting member of staff will certify emergency admissions. The responsible party will be contacted while the patient is in the facility and payment arrangements will be

secured to the facility services.
7. Co-pays and deductibles identified at the time of service and/or at time of insurance verification are to be collected at that time.
8. Patients can receive a 10% discount on balances over $250.00 if paid in full within the first 30 days from the first statement date.
9. MVMC employees receive a 20% discount on all private pay balances and will receive an additional 10% discount if at any time they choose to pay the account balance in full.

Insurance Verification:

Prior to and /or during the patient's stay the responsible party for payment must be identified and the insurance coverage verified, copy of insurance card taken (front and back). Coverage verification includes the following:

1. Effective date of medical coverage.
2. Deductible and co-pay amounts
3. Special billing requirements of third party.
4. Does insurance cover admitting diagnosis?
5. Pre-certification for the patient admission

Insurance Companies Not Billed by the Facility:

If the patient has an insurance plan that is not billable by Madison Valley Medical Center, then that patient's admission will be self-pay. The patient will be notified by either the registration clerk or Business Office Associate that we are unable to bill their insurance and the reason why.

Payment Agreements

All accounts not paid in full at the time of service will be set up on a payment arrangement plan allowing for equal monthly installments to pay off the outstanding balance due at the end of the twelve (12) month period. The payment arrangements may be renegotiated at this time at the discretion of Patient Financial Services. If a satisfactory agreement is not obtainable the account is deemed delinquent and sent for immediate collection action. If patients fail to make a payment per their payment agreement it is appropriate to contact the patient via phone to allow them to make up the missed payment by the time their next payment would be due. If the payer fails to correct the missed payment be sent to manage status. Additional services, which require payments, will result in a new payment arrangement.

Periodically self-pay accounts will be reviewed by the Patient Financial Services Representative and the Revenue Cycle Manager. Accounts will be identified that have outstanding balances that are at least one year old and have had regular monthly payments applied to them. At the discretion of the Revenue Cycle Manager, these patients can be offered discounts per the following matrix:

| **Account Balance** | **Discount** |
|---|---|
| Over $10,000 | 50% |
| $5,000 - $9,999 | 40% |
| $1,000 - $4,999 | 35% |

$100 - $999 25%

Exceptions to this matrix will be approved by the CEO and Revenue Cycle Manager.

Credit Card

Madison Valley Medical Center will accept Discover, Visa, MasterCard and American Express credit cards for payment for account at the time of service for all debts with Madison Valley Medical Center.

Collection Procedure

The facility will recognize each account turned over to collection agency as a bad debt. The facility will recognize an account as bad debt per the credit terms outlined above with the following exceptions:

1. The account is in litigation.
2. The account is pending for Medicare or welfare.
3. Authorized facility personnel have bases for holding the account open.
4. Prior to the terms outlined above, circumstances recognize the account as a bad debt immediate skips, prior account history, etc.
5. By law the account must remain open.

The facility patient accounting staff is to process and document the following before an account is sent to collections:

1. A minimum of three (3) statements must be issued to the responsible party.
2. Correct address and phone number must be verified; if no correct address is given, account will be sent directly to Collection Agency.
3. Payment arrangement contract has been broken and not corrected before the next payment is due (one month without payment). Example: Payment made in August but no payment again until October.
4. One facility reminder letter must be sent.

Department of Social and Health Services (MT Medicaid)

If the patient does not provide the necessary information for billing Medicaid the bill becomes the patient's responsibility. Patient is responsible for choosing their Passport Provider. As a rule, we do not accept out of state Medicaid.

Billing questions or disputed accounts

The patient must contact the hospital within 60 days of the first billing if it is believed that the bill contains errors. The complaint must be in writing. The hospital will research and adjust the bill as appropriate and send a written explanation to the patient within 30 days of receipt of the initial complaint. Payment arrangements must continue to be fulfilled on the bill during the time required for the hospital to research and respond to the complaint.

Self-Pay Accounts

All accounts not billable to an insurance company are deemed self-pay.

Payment

If the patient is private pay the registration staff will inform the patient that they need to contact the Patient Financial Services Representative to resolve the balance within 30 days.

Submission of bills

1. Within seven (7) days of date of services claim form will be generated.  The date this bill is printed becomes the billing date.
2. The bill is built in the EMR via the patient type selection, coding of charges, and with the patient insurance information provided at registration. The file is compiled and submitted into the clearing house to be worked and corrected. It is finally sent to the proper insurance via electronic file or by paper.
3. If a claim has been denied, the reason why will be stated on the Remit and MVMC will correct the claim if necessary and resubmit.