HMH CARRIER CLINIC

Belle Mead, NJ 08502 (908) 281-1000

Title: Billing and Collection Policy	**Chapters:** Fiscal
Author:, Director Billing, and VP/ CFO	**Stakeholders:** ▪ All Staff
Create Date: 11/19 **Revised Date:** **Reviewed Date (T):**	**6 Pages**
References: Federal and state laws, regulations, guidelines and policies	**Executive Signature:** Vice President, CFO

PURPOSE

HMH Carrier Clinic (Carrier Clinic) ensures that accurate, consistent and timely collection procedures are followed and adheres to federal and state regulations including but not limited to the Emergency Treatment and Labor Act (EMTALA), Debt Collection Practices Act, Fair Credit Billing Act, the Centers for Medicare and Medicaid (CMS) Bad Debt Requirements and Section 501(r) by the Internal Revenue Service

This policy provides general guidelines for acquiring and verifying information, collecting payment from third party insurance companies, patients, their guarantors, and other financially responsible parties for the payment of health care services. The policy applies to services delivered and billed by the Hospital excluding those services delivered and billed by the entities listed in Appendix A even in the case where such services may have been rendered at the hospital.

The guiding principles behind this policy are to treat all patients equally with dignity and respect to ensure appropriate billing and collection procedures are uniformly followed and to ensure that reasonable efforts are made to determine whether the individual responsible for payment of all or a portion of a patient account is eligible for assistance under the Financial Assistance Policy.

PROCEDURES

COLLECTION AND VERIFICATION OF PATIENT INFORMATION

It is the patient's responsibility to provide complete and timely insurance and demographic information to the Hospital. Pre-admission, admission or registration occurs at any point in the patient access cycle. The activation of the patient account includes: reviewing demographic, guarantor and insurance information; copying cards; obtaining consents and signatures.

Verification of insurance status and benefits is performed as soon as complete insurance information is available via Health Change (assistant) system. More thorough verification is performed shortly thereafter by accessing insurance on line or by making telephone inquiry.

The requirement to obtain complete information will take the patient's condition into account with the patient's immediate health needs taking priority.

At time of admission when appropriate patient/family may be referred to Patient Services Representative (PSR) to explain hospital payment policy, communicate estimated out of pocket expense, payment options and availability of financial assistance.

EMERGENCY and URGENT ADMISSIONS

All emergency services will be provided without regard to ability to pay. Under no circumstance, hospital staff will attempt to obtain insurance information, verify eligibility or seek admission pre-approval from third party. It is only after confirmation that the patient has been screened and approval given by the admitting provider, the patient may be approached in an attempt to collect insurance information, discuss financial responsibility, payment options and availability of financial assistance.

Non Emergent or Non-Urgent PATIENTS

Registration and intake of Nonemergency, Non-Urgent patient can be performed prior to services being rendered or at the time of admission. Returning or established patients will have their demographic, insurance, and financial information reviewed and updated as needed, including where applicable, verification of patient insurance eligibility via electronic or telephonic methods. Patients have the responsibility to update insurance and demographic information with Registration.

DETERMINATION OF FINANCIAL ASSISTANCE ELIGIBILITY

Subject to the provisions defined in the Carrier Clinic Financial Assistance Policy (FAP) and herein, Carrier Clinic may provide financial assistance for patients who are uninsured, underinsured, ineligible for any government health care benefits program, or who are unable to pay for their care.

An individual can apply for financial assistance by filling out a paper copy of the application. The paper application is available free of charge by any of the following methods:

- **By Mail:** By writing to the following address and requesting a per copy of the financial assistance application: HMH Carrier Clinic 252 County Road 601 Belle Mead, NJ 08502 Attention: Patient Financial Services

- **In Person:** By stopping by the Patient Financial Services Dept. (Monday thru Friday, 8:00AM – 6:00 PM) at the address: HMH Carrier Clinic 252 County Road 601 Belle Mead, NJ 08502
- **By Phone:** The Patient Financial Services Dept. can be reached at 908-281-1554 during the hours of 8:00AM – 4:30PM.
- **Website:** https://www.hackensackmeridianhealth.org/en/Pay-Bill/Financial-Assistance/Carrier-Clinic-Financial-Assistance-Policy

Completed application should be returned to the Patient Financial Services Dept. located at 252 County Road 601 Belle Mead, NJ 08502 with supporting documentation, including but not limited to:

- Most recent federal tax returns for all household members
- Three months of bank statements: savings, checking account and any other investments
- Income sources (last two employment pay stubs, Social Security income award letter or bank deposit proof, unemployment compensation）

Incomplete applications will not be considered, but applicants will be notified and given an opportunity to submit missing documentation.

An individual has 240 days from the date of first post discharge billing statement to submit an application for financial assistance.

All applications are subject to review and approval by CFO. Generally, eligible patients are eligible for Financial Assistance, using a sliding scale, when Household Income is at or below 100% of the Federal Government Federal Poverty Guidelines.

If the patient fails to supply sufficient information to support financial hardship, Carrier Clinic may rely on external sources and/or other program enrollment resources to determine eligibility which must be provided by the patient when:

- Patient is homeless
- Patient is eligible for other state or local assistance programs
- Patient is eligible for food stamps or subsidized lunch program
- Patient is eligible for state funded prescription medication program
- Patient's valid address is considered low-income or subsidize housing
- Patient receives free care from a community clinic and is referred to Carrier for further treatment
- Patient lives in boarding home

DEPOSITS

Insurance deductible, copay, and coinsurance amounts may be requested at time of service. In the event that insurance active status cannot be confirmed or authorization cannot be obtained, the patient may be asked for deposits.

Arrangements may be made to wave this requirement when alternative and acceptable payment arrangements are made and there is no history of bad debt.

IN-HOUSE COLLECTION

If during the course of patient's stay the patient liability has not been established at time of admission, the patient or guarantor may be contacted and requested to make interim payments and /or payment arrangements.

Patient Service Representatives are available to provide information or answer questions about insurance eligibility and benefits. The contact information is provided in the Patient Handbook and at hospital units.

INSURANCE VERIFICATION

The hospital staff will verify eligibility and benefits prior to admission or shortly after the admission, but cannot guarantee the accuracy of the insurance eligibility and benefit information it receives from the insurance carrier.

AUTHORIZATION

The hospital staff will obtain approval from third party payers to provide specified care via written or verbal means that the services provided will be authorized under the term of the patient's healthcare plan. Authorization does not validate eligibility or benefits, nor does it guarantee payment.

AUTHORIZATION DENIALS

The patient and/or the guarantor will be notified as soon as insurance carrier no longer approves continued stay. The patient/guarantor will receive explanation on the appeal process including external appeal available to patients. The patient/guarantor will be asked to complete acceptance of financial responsibility for non-authorized days and may be asked for deposits.

PAYMENT ARRANGEMENTS

If the patient is unable to make full payment when due, partial payments may be approved. A patient's financial proof of hardship may be requested to determine acceptable payment arrangements that will meet patient and hospital needs. Financial Eligibility criteria are discussed with every patient and/or guarantor when financial hardship is presented and when appropriate.

PAYMENT METHODS

The following payment methods are accepted: cash, check, ~~and~~ money order, Visa, MasterCard, American Express, and Discover Card.

NON-SUFFICIENT FUNDS (NSF)

$25.00 processing fee will be applied to the patient's account on all returned checks.

REFUNDS

All patient refunds are reviewed weekly and forwarded to PFS Director and/or Office Manager and CFO for approval. Any overpayment of account balance will be applied to the outstanding balance for the same patient and the same guarantor. If there are no outstanding debts, the payment will be refunded in coordination with all parties who made payments in creating the credit balance. All patient refunds will be issued using the same method as the original payment.

PATIENT STATEMENTS AND COLLECTION TIMELINESS

Carrier Clinic utilizes Arcadia Recovery Services (ARS), Inc. for collection of all patient balances after insurance payments and uninsured individuals. The total billing cycle is 120 days before the balance is sent to an outside collection agency.

ARS collection activity includes the following:

- Five phone calls (day 15; 40; 50; 75; 110) when valid phone number exists.
- In addition, four statements are generated and mailed to the address of record for the patient
    - For patient balances after insurance payment, statements issued on the following timeliness post insurance payment date on day 1; 30; 60; 90 (final statement).

The billing statements include the following:

- Patient name, demographics, address, date(s) of service, account number, amounts charged and amounts paid, adjustments and amount due
- ARS contact information
- Carrier Clinic Financial Assistance Policy Plain Language Summary

Patients with inquiries regarding their balance can call the Customer Service Dept. 800-888-1301 (Mon – Wed 8AM -7PM; Thurs-Fri 8AM -6PM) or Patient Financial Services 908-281-1554

Address for payments:
HMH Carrier Clinic, Inc.
ATT: Finance/AP

PO Box 147
Belle Mead, NJ 08502-0147

ACTION IN THE EVENT OF NO PAYMENT

The Hospital will make reasonable efforts to provide patients with the opportunity to meet their financial obligation as noted above in the section above titled "Patient Statements and Collection Timeliness" before an account is referred to the outside collection agency.
Arcadia will provide information on financial assistance and payment options. Patients may also access HMH Carrier Clinic's Financial Assistance Policy (FAP) thru the website https://www.hackensackmeridianhealth.org/en/Pay-Bill/Financial-Assistance/Carrier-Clinic-Financial-Assistance-Policy, or contacting a billing representative through one of the following:

- **By Mail:** By writing to the following address and requesting a copy of the financial assistance application: HMH Carrier Clinic 252 County Road 601 Belle Mead, NJ 08502 Attention: Patient Financial Services
- **In Person:** Administration Bldg (Patient Financial Services Dept.) 252 County Road 601 Belle Mead, NJ 08502 (Monday thru Friday, 8:00AM – 4:30PM)
- **By Phone:** The Patient Financial Services Dept. can be reached at 908-281-1554 during the hours of 8:00AM - 4:30PM

Any balances still owed upon exhaustion of billing statement timeliness and/or finalization of any financial assistance will result in the patient account to be referred to the outside collection agency.

REFERRAL TO OUTSIDE COLLECTION AGENCY

The total billing cycle is 120 days before the balance is sent to collection, as defined in the section: PATIENT STATEMENTS AND COLLECTION TIMELINESS.

If payment is not received, the account will be referred to a Collection Agency.

HMH Carrier Clinic, Arcadia Recovery Services and Collection Agency efforts do not include Extraordinary Collection Measures.