Billing and Collection Practices

NMC Northwestern Medical Center	**Document Classification:**	☒ Policy ☐Procedure ☐ Guideline ☐ Protocol
	Document Type:	☒ Administrative ☐ Clinical
	Applicability:	☒ Organization ☐ Hospital ☐ NMG ☐ Department Only

Effective Date: 12/2007	**Last Reviewed/Revised Date:** 05/2022	**Last Approval Date: 06/13/2022**

KPO:	Revenue Cycle Manager/Privacy Officer	**Department:**	Patient Financial Services
Key Stakeholders:	Patient Financial Services Supervisor		
Approved by: Chief Financial Officer			
Associated Procedure(s):			

Purpose: This policy establishes Northwestern Medical Center and Northwestern Occupational Health's principles and guidelines for patient billing and collection practices. Related policies include:

- Bad Debts
- Discounts for Medical Services Provided
- Financial Assistance
- Patient Payment Plans

Policy: See purpose statement above.

Definitions:

Follow-up and Collection – Defined as account processing after billing has occurred, that is proactive, timely and efficient in moving an account toward resolution.

An account process is considered "proactive" when an active intervention occurs to move the account further along toward a more timely resolution and/or favorable outcome. It is important that the intervention takes place before a potential processing breakdown that will require additional time spent reacting to problems, such as denials.

To be considered "timely", a certain population of accounts – those with unpaid gross charges of $10,000 or more shall receive staff intervention no less frequently than every 15 days. All other accounts shall receive staff intervention at least once every 30 days.

Account processing is "effective" when each intervention clearly moves the account toward a more timely and/or favorable outcome. Moreover, no actions on one specific account (or

group of interim accounts for the same patient) should be repeated. For example, after ongoing follow-up with a payer regarding a delinquent payment, it is never appropriate to accept the same answer, such as, "we don't have the claim yet" or "the claim is in processing and should pay in the next couple of weeks." Effective account processing can only result when each incidence of contact escalates progress toward resolution.

Policy Provisions: N/A

Procedure:

GENERAL PRINCIPLES

1. All patients will be treated fairly, with dignity, compassion and respect.

2. Northwestern Medical Center and Northwestern Occupational Health (the "Hospital") has developed separate financial assistance policies that are consistent with its mission and values. These policies, which are broadly communicated, reflect a commitment to provide financial assistance to patients who cannot pay for part or all of the care they receive.

3. The Hospital's financial assistance policies balance a patient's need for financial assistance with the Hospital's broader financial responsibilities.

4. Debt collection policies (provided herein), both for the Hospital and its external collection agencies, reflect the Hospital's mission and values.

5. Financial assistance provided by the Hospital is not a substitute for personal responsibility. All patients are expected to contribute to the cost of their care, based upon their individual ability to pay.

6. Financial assistance will be available for both uninsured and underinsured patients, including patients that do not have the financial ability to pay for their coinsurance and deductible portions after their insurance has paid.

7. The Hospital will endeavor to provide patients with "user friendly" billing statements. In this regard, the Hospital will utilize the Patient Friendly Billing standards and recommendations of the Healthcare Financial Management Association.

8. The Hospital will be an adopter of the Healthcare Financial Management Patient Financial Communications Best Practices Program.

POINT OF SERVICE COLLECTIONS

Medical services will be provided to patients regardless of ability to pay, except for elective

services, i.e., teeth extractions, voluntary sterilizations, and cosmetic surgery.

The Hospital's goal is to pre-register as many patients as possible. This affords the Hospital time in advance of providing the service, to verify insurance coverage, including patient deductible and copay amounts, and to discuss payment arrangements in advance with the patient, including patient financial assistance programs available by the Hospital and other agencies. In circumstances where it is possible to estimate the charges for services during the pre-registration process, the Hospital communicates this information to the patient and requests advance payment of any deductible or copay amounts. Elective services require payment in full in advance, including any outstanding balances related to prior services, unless approved by the Patient Financial Services Manager.

Patients receiving services in the ED shall be directed to the ED registrar after services are rendered in order to make any deductible or copay payments. Inpatients and observation patients will be visited by a Patient Financial Services representative to discuss and collect on self-pay accounts, deductibles and copays while the patient is on the nursing unit, if not arranged prior to admission. NMC's financial assistance program and payment plans will also be discussed with the patient at that time, as appropriate.

For all other patients that receive other outpatient services that are not pre-registered, registrars will attempt to collect in advance any copay amounts due for services to be rendered if indicated and determinable by information contained on the patient's insurance card or insurance company's website. Any patients that do not have insurance coverage that cannot pay for their services shall be directed to a Patient Financial Services Certified Financial Counselor for further assistance.

BILLING FOLLOW-UP AND COLLECTION PRACTICES

Billing follow-up and collection responsibilities are generally allocated amongst Patient Financial Services staff by payer. The Manager of Patient Financial Services and Patient Financial Services Senior Biller provide assistance on collecting larger balance accounts that we experience payment delays on.

The follow-up and collection activities shall be performed as defined above. It is expected that account worklists and/or accounts receivable aging reports will be used by staff to assist them in their follow-up and collection activities. Work queues are periodically reviewed by the Manager of Patient Financial Services and Patient Financial Services Senior biller to ensure timely follow-up and collection. All follow-up and collection activities shall be documented in the on-line notes section of the patient billing software.

The Chief Financial Officer reviews aging reports by financial classification monthly to identify trends.

FOLLOW-UP AND COLLECTION ON SELF-PAY BALANCES

The Hospital has chosen to outsource the billing and collections of their self-pay balances to a Billing Service. Each bill will include a statement that indicates that the Hospital offers financial assistance to its patients that meet established criteria, how to obtain additional information and how to obtain an application for financial assistance. All companies performing billing and collection functions for the Hospital will be provided and will be required to comply with all of Hospital collections and financial assistance policies.

Patient balance statements will be sent out every thirty days. The statements will include all accounts and service dates having a self-pay balance for each patient. The third statement will inform the patient/guarantor of the possibility of their account being transferred to a collection agency unless a financial assistance application is submitted and/or payment arrangements have been made within 30 days of the statement. Any accounts unresolved that are one hundred twenty days old (measured from the date the first bill was sent to the patient) will be moved from "pre-collections" to "collections". This will also include reporting the individual to the credit reporting agencies for outstanding balances in excess of $50. There are exceptions for patients who have an application pending for either government-sponsored coverage (e.g. Medicaid) or for the Hospital's financial assistance program, and/or they are reasonably cooperating with the Hospital in an effort to settle an outstanding bill. Under these exceptions, the Hospital may not send their bill to a collection agency.

Telephone calls will be placed to patients/guarantors on all accounts after the first statement has been sent. If unable to reach the patient/guarantor on the first attempt the "Billing Service" will place calls until they reach the patient/guarantor. Monthly calls will continue until the account is resolved. Patients are advised that all calls are being recorded.

During the collection process, financial assistance, a payment plan, or a discount may be offered to the patient, if appropriate, and in accordance with established Hospital policy. Patients working with the Hospital's Billing Service that request financial assistance will be directed back to NMC for processing. The Billing Service will return to NMC all accounts which are granted financial assistance.

Any legal actions to be taken against the patient for outstanding amounts owed to the Hospital, including such actions that may be taken by the Hospital's collection agencies, must be approved by the CFO (unless otherwise noted below), and are subject to the following guidelines:

- Liens may be placed on assets, including primary residences for outstanding balances in excess of $5,000; however, foreclosures on primary residences are prohibited.
- Liens may be placed on a patient's third-party claims, i.e., automobile accidents, with the exception of verified workers' compensation claims. No CFO approval is required.
- Wage garnishments are not permitted.

- Liens against judgments are permitted.

Legal action shall be considered a last resort after all reasonable collection efforts have been exhausted. Charges incurred related to any legal fees and court costs may be charged to the patient.

If there is no means to contact the patient or patient's family, i.e., phone number is disconnected, return mail, Hospital staff may utilize skip tracing, access to databases, or other reasonable and lawful means to locate and communicate with the patient or their legal representative to attempt collection. As soon as it is determined that the patient or their legal representative cannot be located or contacted, the balance will be referred to a collection agency.

References:

Patient Protection and Affordable Care Act

IRS Notice 2014-2 issued on December 30, 2013

Healthcare Financial Management Association Patient Financial Communications Best Practices (2014)

Healthcare Financial Management Association Patient Friendly Billing Guidelines