

**POLICY & PROCEDURE**

**Subject:** MARIANJOY- Payment for Services

**Classification:** Senior Leadership Approved

**Policy Owner:** Financial Services

**Approved by:** Sr. VP/ CFO

**Effective: April 1, 2009**

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**POLICY:** Marianjoy provides medically necessary health care services to people in the communities it serves. No person shall be denied emergent or urgent care or receive less than the appropriate level of care based on ability to pay. However, in order to sustain its ability to meet this commitment, MARIANJOY uses standardized procedures in the collection of payment for the health care services and supplies it renders.

**RATIONALE:** Faithfulness to our mission and values of respect and integrity calls every organization that is part of MARIANJOY to provide all persons who come to us with the medical care they need without regard for ability to pay. Faithfulness to our value of stewardship calls us to do all in our power to ensure our financial ability to continue to carry out the healing ministry of Jesus with particular attention to the poor.

We understand it to be our obligation, then, to have in place specific procedures and guidelines which clearly articulate our responsibility to those who have no means of reimbursement, to those who need assistance in identifying and accessing such means, and to ourselves when reimbursement is available but not forthcoming. In this way we live our value of integrity and excellence.

It is our intention to fulfill our responsibilities with respect for every person affected and with attention to the cultural, ethnic and language realities, which influence our interactions.

**SCOPE:** This policy applies to all tier III organizations under Marianjoy, Inc.

## PROCEDURE:

## PAYMENT FOR SERVICES

### **Communications Requirements**

At the first point of contact, patients will receive from each MARIANJOY provider a standard notice regarding the MARIANJOY policy on payment for services and other potential financial assistance available to eligible individuals. Such notice shall be written in a clear manner that facilitates patient understanding and shall be posted in all MARIANJOY provider registration areas and all ancillary departments.

### **Authorization Coordination**

Eligibility and benefits will be verified for all services that require prior-authorization where possible. This preauthorization requirement will not apply to emergency services or otherwise be used to limit access to medically necessary urgent care. Patients shall not be illegally discriminated against based on source of payment or ability to pay.

### **Billing and Collection Process**

#### **Third-party Payors**

MARIANJOY providers (and/or their billing and collection agents) will submit all primary, secondary and tertiary bills for services actually rendered to the appropriate federal or state program, commercial insurance, self-insured funds, HMO, PPO or other third-party payor program(s) (referred to herein as "payor(s)"). Payment of these claims will be in accordance with the contractual agreements in place with these payors. Any patient responsibility for payment remaining after such submission or resolution of the claim with a particular payor will be handled in the manner described below or as otherwise required by existing contractual agreements with the payor and/or applicable law. Any amounts that are found to be Medically Necessary but not covered by an insurance plan are to be treated under self pay procedures and all applicable payer rules are to be followed (i.e. ABN.)

#### **Self-pay Payors**

- A. At the time of scheduling or registration, the MARIANJOY provider assesses the patient's source of payment for the services to be furnished. Uninsured patients seeking elective, but still medically necessary procedures, will meet with the appropriate staff prior to the services being rendered. The staff person will assist the patient with enrollment in state or federal programs as applicable, advise the patient of the self-payor discount, assess whether the patient is eligible to participate in the MARIANJOY Community Care Program, or assist the patient in establishing payment arrangements. For emergent or urgent care services, these assessments may occur after the services are rendered.
- B. At the time these assessments are made, the MARIANJOY provider discusses with the patient his or her responsibilities for payment, if any, and furnishes any necessary "Advanced Beneficiary Notices," as required by Medicare, or similar non-covered or patient responsibility notices. Information regarding self-payor discounts and the MARIANJOY Community Care Program also is provided at this time.
- C. Co-payments, co-insurance, deductibles or similar patient responsibility amounts identified are to be collected by MARIANJOY at the time of service unless otherwise specified by the applicable payor. For emergent or urgent

care services, these amounts will be collected after the services are rendered (either upon discharge or otherwise in accordance with the collection procedures outlined herein) or as otherwise specified by the applicable payor. Time of service collections will follow the guidelines outlined below:

**Emergent/Urgent**

In accordance with applicable law and policy, as required, request of payment will be discussed after the patient has had medical screening; the appropriate staff person will also assist the patient with enrollment in State or Federal programs, establish payment arrangements or assess the patient for Community Care eligibility once a medical screening has been completed.

If the patient leaves without presenting to the discharge area and has a financial obligation, a letter will be sent requesting the identified amount be mailed in.

Patients will be requested to make a 'good faith' payment prior to discharge, if the patient is not eligible for any other assistance programs as outlined in "a" above.

In no case shall patients be denied access to urgent medically necessary care based on source of payment or ability to pay.

**Scheduled/Non-Emergent or Elective Services**

If the patient's financial history indicates consistent non-payment and the patient is not eligible for other payment sources or assistance programs, the patient will be requested to make payment arrangements and fulfill past due balances prior to scheduling additional non-emergent or elective services.

**Walk-in/Unscheduled Non-Emergent or Elective Services**

If the patient's financial history indicates consistent non-payment and the patient is not eligible for other payment sources or assistance programs, the patient will be requested to make payment arrangements and fulfill past due balances prior to services being performed.

In no case shall patients be denied access to urgent medically necessary care based on source of payment or ability to pay.

D. For amounts that are determined to be the patient's or his or her guarantor's responsibility, a cycle of statements should be initiated with reasonable intervals to allow the patient/guarantor an opportunity to contact the MARIANJOY provider (or its billing and collection agent) if payment in full cannot be made.

- Reasonable collection Efforts will be pursued by the MARIANJOY provider prior to referring an account to a collection agency and/or reclassification of the account into bad debt.
- Unless specified by an applicable law or a particular payor, reasonable collection efforts are defined as at least two (2) statements including a final notice mailed to the guarantor's home address. Reasonable collection efforts may also include up to two (2) phone contacts to the guarantor's home phone number.
- All statements contain standard language that states that payment in full

is expected. These statements are written in a clear manner that seeks to facilitate the guarantor's understanding of his or her responsibilities and include:

- ☒ Date of service
  - ☒ Payor billed, if applicable
  - ☒ Summary charge information
  - ☒ Self-payor discount amount (including text that indicates such discount is contingent on payment or maintenance of payment plan and such discount could be reduced for failure to make payment or adhere to payment plan)
  - ☒ Balance due
  - ☒ Phone number for the business office customer service department.
- The statement cycle is to be completed on average within 90 days from the date the account transfers to a self-pay status.
  - For self-pay guarantors, the MARIANJOY provider may establish interest free installment payment arrangements for the guarantor to pay any balances over a four (4) month period. At the option of the MARIANJOY provider, payment plans with duration of up to 12 months may be established and sent to an outside agency to be monitored. These payment plans must have a minimum monthly payment of \$50. Any arrangements greater than 12 months in duration will be sent to the collection agency unless the MARIANJOY provider determines otherwise.
  - Unless otherwise specified by the MARIANJOY provider, small balance accounts that meet or fall below a specified threshold established by the MARIANJOY may be classified into the small balance write-off code and not classified as bad debt with a collection agency.
  - If the patient's self-pay history indicates consistent non-payment and the patient is not eligible for other payment sources in accordance with applicable law the patient shall be referred to other community health care sources for non-emergent services.

MARIANJOY Associates

MARIANJOY Associates will be offered the option of payroll deductions to fulfill their financial obligation.

**Collection Agency Protocol**

- A. Any collection agency used by MARIANJOY will adhere to state and federal debt collection laws as well as this policy with regard to collection parameters of practice.
- B. Collection agencies will accept placements from MARIANJOY at a minimum of once per month.
- C. Collection agencies will issue to MARIANJOY at least monthly notices of collection activity and closed accounts.
- D. All legal action must be approved by MARIANJOY referring a placement.
- E. In accordance with applicable law, their contract and MARIANJOY policies

and procedures, collections agencies will pursue reasonable collection efforts that include the following when appropriate:

- Collection calls and letters
- Credit bureau reporting
- Property liens
- Garnishment of wages
- Collection based on the sale of a residence in accordance with state law.

- F. The following collection practices are unacceptable by any MARIANJOY provider or billing or collection agency operating on behalf of MARIANJOY:
- Bodily harm threats
  - Body attachments
  - Initiation of foreclosure of the principal residence while owned or occupied by the patient or his or her spouse.

### **Collection Agency Expectations**

All collection agency contracts, both new and existing, shall include language acknowledging that the collection agency has received information from MARIANJOY regarding the Mission, Vision and Values and agrees that in the performance of all of its obligations under the terms of its agreement with MARIANJOY it shall at all times conduct itself, and take reasonable actions to ensure that its employees and agents conduct themselves, in a manner which is consistent with MARIANJOY's Mission, Vision and Values.

## **COMMUNITY CARE PROGRAM**

### **Community Care Program Requirements**

MARIANJOY will provide written notice to its patients and guarantors of its Community Care Program and information as to how a patient may apply for financial assistance under such Program. This program will comply with all state and local rules and regulations regarding self pay patients. Self pay patients will be considered those without any type of insurance, patients with exhausted benefits and patients that receive non-covered but medically necessary procedures.

- A. As set forth above, all uninsured patients should be evaluated for their ability to pay or otherwise receive reimbursement for their services during the scheduling, registration process, first point of access, or as soon as possible thereafter. Identification of a financial hardship, however, can take place at any time during the collection process.
- B. Patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program or staff for assistance in enrollment.
- C. The Community Care Program is available to all residents of the state in which the MARIANJOY provider entity is located. Unless otherwise required, applicants must be a resident of that state for a minimum of 90 days prior to the date of the service.
- D. Ordinarily, a Community Care Program application must be completed within a year of the date of service, but preferably before being sent to the collection agency, except as determined by the senior vice president of finance. Approved applications for community care will be valid for one year

from approval or the duration of the course of treatment contemplated in the application, whichever is longer, provided that during such time frame MARIANJOY has not received notice of any change in the patient's financial situation. The patient shall be informed as part of the application process that he or she is responsible for notifying the MARIANJOY provider in the event that there is a change in his or her financial situation. Patients who require unrelated treatment during that year can attest to the accuracy and completeness of their Community Care Program application as adequate verification.

- E. Patients determined to have potential eligibility in other governmental programs, but fail to comply with completing appropriate paperwork, will not be eligible for the Community Care Program and shall be referred to other community health care sources for non-emergent services. Additionally, patient who fail to provide requested information to potential third-party payors that results in a denial will not be eligible for the Community Care Program.
- F. Services deemed not medically necessary, as determined by a physician, are not eligible to be covered under the Community Care Program.
- G. Services that are medically necessary but not covered by Medicaid are considered to be community care by default as income and asset limits for Medicaid are congruent with our community care program. These patients will not require a community care application.

**Determination of Patient Eligibility for Community Care Program**

All patients identified as potentially eligible for community care are referred to the appropriate staff and must complete a Community Care Program application ([Appendix A](#)).

- A. The Community Care Program application requires completion of the following information:
  - Family size
  - Monthly income
  - Assets/liabilities
  - Other sources of Income (i.e. alimony, child support, unemployment compensation, etc.)
  - Equity value in home
- B. Additionally, as part of the Community Care Program application process, individuals will be asked to attest to the accuracy and completeness of the application and to submit the following materials for verification:
  - Latest tax returns
  - Bank statement
  - Application to applicable state agencies for eligible governmental programs.
- C. Upon review of the Community Care Program application, a sliding fee scale will be used based on Federal Poverty Guidelines (<http://aspe.hhs.gov/poverty/index.shtml>), assets, family size and home equity ([Appendix B](#)).
- D. The designated business office manager or director will be responsible for reviewing, approving or rejecting all Community Care Program applications based on the documentation provided. It is the responsibility to inform the

program leader of all determinations.

### **Notification of Community Care Program Eligibility Determination**

Written notification of eligibility determination will be provided to each patient identifying the payment for services due and the amount to apply to community care, if any.

### **DISCOUNTING GUIDELINES**

Except as provided in B. below, the MARIANJOY provider will not routinely offer or provide a discount or waive a copayment or deductible. Where necessary and appropriate and consistent with payor rules to the extent they apply, approval may be sought for non-routine discounts or waivers in the following limited circumstances.

#### **A. Risk Management**

Periodic non-routine discounts off established fees may be authorized for risk management considerations after consultation with the regional director of risk management and after appropriate documentation is completed.

#### **B. Uninsured Patients**

The MARIANJOY provider will offer a discount that is regionally based, annually calculated, and consistent with the discounts allowed to the weighted average of the three largest managed care payors, or such other similar criteria as established by the CFO. This discount will apply if payment is received within 120 days of the first statement or contact made with the patient or an acceptable payment arrangement has been established. If no payment or payment arrangements have been made within 120 days after an account becomes a self-pay account, that account will be referred to collection and the discount may be reduced to a discount equaling the lowest discount offered a managed care provider by the MARIANJOY provider involved. In all situations, Provider reserves the right to reverse the discounts described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations of the Provider. Determinations concerning application of any self-payor discount may be appealed to and resolved by the regional vice president for revenue cycle.

### **DEFINITIONS:**

**Assets** – may exclude a patient from the 25% maximum collectible amount who has substantial assets (defined as a value in excess of 600% FPL in urban areas). Certain assets are not considered: primary residence, personal property exempt from collections under Section 5/12-1001 of the Illinois Code of Civil Procedure (see Appendix A), and any amounts held in a pension or retirement plan.

**Authorization** – Activity completed to ensure payment of services for both the patient and the provider.

**Benefit checking/availability** – Determination of covered services and the level of payment.

**Case Rate** – A facility established rate for specified elective services such as cosmetics and bariatrics that are non-billable to insurance.

**Community Care Application** – Process by which patient provides full financial

disclosure for eligibility determination within the terms of this policy.

**Discount** – An allowance or deduction made from the provider's standard charge.

**Elective** – Patient's condition permits adequate time to schedule the availability of a suitable accommodation.

**Eligibility checking** – Verification of an active insurance policy or payor source available.

**Emergent** – Patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.

**Family** – The patient, his or her spouse, including a legal common-law spouse, and his/her legal dependents according to the federal internal revenue rules.

**Financial Screening** – Process used to determine ability of the patient to pay for services within the guidelines established by this policy.

**Federal Poverty Guideline** – Level of income determined annually by the Department of Health and Human Services to indicate a threshold of poverty.

**Income** – Funds generated as a result of employment or ownership of assets.

Maximum Amount - Maximum amount collected in a 12-month period from an eligible Amount: patient is 25% of family's annual gross income. Time period begins as of the first date of service determined to be eligible for discount. For any subsequent services to be included in the maximum, the patient must inform the hospital that he/she had received prior services from that hospital which were determined to be eligible for discount.

**Medical Group** – Medical professional service providers employed by the organization.

**Medical Necessity** – Delay of treatment will cause further deterioration of illness or injury.

**Medical Screening** – Process used to determine health status to determine if emergent care is needed of if issue is non-emergent.

**Non-emergent** – Patient's condition does not require immediate medical intervention.

**Pre-authorization** – Notification to a payor prior to providing service, resulting in an authorization for services and payment being issued by the carrier.

**Private Pay** – Patients who are subject to full charges, without the benefits of any third party payment sources.

**Reasonable Collection Efforts** – Consists of at least three (3) statements including a final notice being mailed to the guarantor's home address and may also include up to two (2) phone contacts to the guarantor's home phone number.

**Referral** – The facilitation of authorization of services from one provider to

another.

**Self-pay Payor**– The financial obligation of the individual receiving service or that person’s guarantor.

**Servicing Department** – Department that assists the patient with their health care needs at initial point of service.

**Small Balance** – Account balance due which is not subject to collection agency activity.

**Payor or Third-party Payor** -- Entity financially obligated for services rendered to an enrollee or assignee.

**Urgent** – Patient requires immediate attention for care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.

**Uninsured patients** – A patient for which there is no insurance coverage or payment from any third party payor, and patient is not aware of any other source of payment for the procedure.

**MARIANJOY Provider** – Any MARIANJOY owned or operated entity furnishing health care services, but excluding retail pharmacy.

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<b>Replaces:</b>	WFH Payment for Services Policy
<b>Cross reference:</b>	Hospital Uninsured Patient Discount Act 095-0965
<b>Review Period:</b>	Two (2) years
<b>Original Policy Date:</b>	April 1, 2009
<b>Dates Updated:</b>	

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