MercyOne Northeast Iowa (MercyOne) 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. In order to sustain its ability to meet this commitment, MercyOne 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 MercyOne to provide all persons with the necessary medical care 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 Christian tradition with particular attention to the poor.

We understand it to be our obligation to have in place specific procedures and guidelines which clearly articulate our responsibility to those who have no means of payment, 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 the Revenue Operations of MercyOne Northeast Iowa.

**Procedure**

**I. Payment for Services**

**A. Communications Requirements**

At the first point of contact, patients will receive from each MercyOne provider a standard notice regarding the MercyOne practice 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 MercyOne provider registration areas and all ancillary departments.

**B. Authorization Coordination**

Eligibility and benefits will be verified for all services that require prior authorization. Additional eligibility and benefits will be verified based upon cost of services, incidents of denials or mutual agreement of involved leaders with consideration given to staffing and
cost effectiveness. Authorization will be secured prior to the service being provided or as outlined below.

1. Scheduled Inpatients - Authorization will be secured prior to or within two business days of admission. Non-urgent services may be delayed until authorization is obtained.

2. Outpatients/Office Visits
   a. Routine, non-urgent or non-emergent services will not be scheduled until authorization is obtained.
   b. Non-scheduled, non-emergent services that require authorization will be postponed until authorization is obtained.
   c. If applicable, authorizations will be secured for provider-to-provider services (referrals).

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 discriminated against based on source of payment or ability to pay.

C. Billing and Collection Process

1. Third-party Payers: MercyOne providers (and/or their billing agencies) will submit all primary, secondary and tertiary claims for services rendered to the appropriate federal or state program, commercial insurance, self-insured funds, HMO, PPO or other third-party payer program(s) (referred to herein as "payer(s)"). Payment of these claims will be in accordance with the contractual agreements in place with these payers or applicable state or federal laws. Any patient responsibility for payment remaining after such submission or resolution of the claim with a particular payer will be handled in the manner described below or as otherwise required by existing contractual agreements with the payer and/or applicable law.

2. Self-pay
   a. At the time of scheduling or registration, the MercyOne provider will review the patient’s financial history for previous bad debt activity, determine any outstanding balances due and assess the patient’s source of payment for the services to be furnished. Uninsured patients seeking elective medically necessary care will be scheduled to 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, will advise the patient of the Self Pay discount described below, will assess whether the patient is eligible to participate in the MercyOne Community Care Program, and/or will assist the patient in establishing payment arrangements. Failure by patients to cooperate with the enrollment and application process for state and/or federal programs as well as the MercyOne Community Care Program or, if applicable, to establish payment arrangements may result in cancellation of non-emergent scheduled services. For emergent or urgent care services, these assessments will occur after services are rendered.

   b. MercyOne offers a Self-Pay discount at the rate of 40% applied to total charges. Patients requiring additional financial assistance are referred to the Patient Financial Assistance/Community Care Program.
c. At the time the financial assessment is made, the MercyOne provider shall discuss with the patient his or her responsibilities for payment and collect a deposit, if applicable, and furnish any necessary “Advanced Beneficiary Notices” as required by Medicare or similar non-covered services or patient responsibility notices.

d. Co-payments, co-insurance, deductibles or similar patient responsibility amounts identified are to be collected by the MercyOne provider at the time of service. 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). Time of service collections will follow the guidelines outlined below.

3. Emergent/Urgent
   a. In accordance with applicable law and policy, request of payment will be made after completion of a medical screening. Once a medical screening has been completed, if applicable, the appropriate staff person will assist the patient with enrollment in State or Federal program, establish payment arrangements or assess the patient for Community Care eligibility.

   b. If the patient leaves without meeting with the appropriate staff and has a financial obligation, the routine billing and statement process will be followed which includes information about available financial assistance.

   c. If the patient is uninsured and not eligible for financial assistance previously described, the patient will be asked to make a good faith payment prior to discharge. In no case shall the patient be denied access to urgent or emergent medically necessary care based on source of payment or ability to pay.

4. Scheduled/Non-Emergent or Elective Services
   a) Insured Patients: 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. Additionally, Patient Access staff will determine the amount of patient liability (e.g. copayment, deductible or coinsurance) due under the insurance plan and shall request payment of the patient liability prior to rendition of these services. If the patient expresses financial hardship, they will be offered a deposit option or an invitation to meet with a financial counselor to discuss financial assistance.

   b) Uninsured Patients: 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. Patients who may be eligible for government programs or financial assistance will be scheduled to meet with a financial counselor who will provide
assistance in applying for government programs and/or MercyOne’s Community Care program.

5. **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 the patient be denied access to urgent medically necessary care based on source of payment or ability to pay.

6. **Case Rate (cosmetics/bariatrics/etc.)**
   Provider will collect 100% of the established case rate prior to the procedure. The case rate is for defined services and is an estimate of total patient responsibility. The patient is responsible for any additional or different services provided in the course of treatment that were not included in the original case rate. Any additional financial obligation will be due within 30 days following the patient’s date of service and/or discharge.

7. **Statements and Collection Efforts**
   For amounts that are determined to be the patient or guarantor’s responsibility, a cycle of statements will be initiated with reasonable intervals to allow the patient/guarantor an opportunity to contact the MercyOne provider (or its billing and collection agent) if payment in full cannot be made.

   a. Reasonable Collection Efforts will be pursued by the MercyOne provider prior to referring an account to a collection agency and/or reclassification of the account as bad debt.

   b. Unless specified by an applicable law or a particular payer, reasonable collection efforts will include a series of three statements, one of which will be a final notice mailed to the patient/guarantor's home address. Reasonable Collection Efforts also include letters and telephone contacts to the patient/guarantor's home telephone number or other patient/guarantor telephone number provided. Each letter will include information concerning the availability of financial assistance and how to apply.

   c. All statements contain standard language stating that payment in full is expected. The statements are written in a clear manner to facilitate the patient/guarantor’s understanding of responsibilities and include:
      i. Date of service
      ii. Summary charge information
      iii. Self-pay and/or contractual discount amount
      iv. Balance due
      v. Phone number for the customer service department.
      vi. Statement regarding financial assistance
      vii. Web address
d. The statement cycle is to be completed no less than 120 days from the date the account transfers to a self-pay status.

e. If the patient/guarantor is determined to be eligible for financial assistance within 365 days after the first post-discharge bill, all extraordinary collection actions will be reversed.

f. MercyOne may establish interest free installment payment arrangements for the patient/guarantor to pay any balances over a twelve (12) month period. Dependent upon circumstances and/or balance of the account, payment arrangement for additional months may be established.

g. Unless otherwise specified by the MercyOne provider, small balance accounts that meet or fall below a specified threshold (less than $10) may be adjusted off as a small balance write-off and not classified as bad debt with a collection agency.

h. If the patient/guarantor’s self-pay history indicates consistent non-payment and the patient/guarantor is not eligible for other payment sources in accordance with applicable law, the patient/guarantor shall be referred to other community health care sources for non-emergent services.

i. MercyOne colleagues will be offered the option of payroll deductions to fulfill their financial obligation.

j. The final payment notice statement will be sent no less than 30 days before extraordinary collection actions are taken including the following:
   i. Deadline for payment
   ii. Availability of Financial Assistance
   iii. Plain Language summary document of the financial assistance policy

D. Collection Agency Protocol

1. Any collection agency used by the MercyOne provider will adhere to state and federal debt collection laws as well as this policy with regard to collection parameters. Collection agencies will accept placements from the MercyOne provider at a minimum of once per month. Collection agencies will issue to the MercyOne provider at least monthly notices of collection activity and closed accounts. All legal action must be approved by the MercyOne provider entity referring the placement.

2. In accordance with applicable law, their contract and the MercyOne provider’s policies and procedures, collections agencies will pursue reasonable collection efforts that include the following when appropriate:

   a. Collection calls and letters
   b. Credit bureau reporting
   c. Property and liability liens
   d. Garnishment of wages
   e. Collection based on the sale of a residence in accordance with state law.
   f. Collection based on patient securing a home equity or other personal loan
g. Defer scheduling of non-urgent or non-emergent services  
h. Commencing a civil action  

3. The following collection practices are unacceptable by any MercyOne provider or billing and collection agency operating on behalf of MercyOne:  
   a. Bodily harm threats  
   b. Body attachments  
   c. Initiation of foreclosure of the principal residence while owned or occupied by the patient or his or her spouse or guarantor  

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

E. Internal Legal Processes  
1. MercyOne provider staff will prepare and file the appropriate legal documentation in the following cases to attempt to secure payment for services rendered:  
   a. Hospital and/or medical liens may be filed in accident related cases, following applicable federal and state laws.  
   b. Probates will be filed for deceased patients with the potential for reimbursement. Deceased patients without probate may be included as part of the Community Care Program, as applicable.  
   c. Bankruptcy covered accounts will be identified and standard collection efforts will cease while payment is sought through the bankruptcy process.  
   d. If special circumstances exist, consultation with the appropriate legal counsel will be sought prior to a final decision by the Vice President of Finance or designate.  

II. MERCYONE DISCOUNTING GUIDELINES  

Unless an insured patient is eligible for the Community Care Program or if Section A below applies, MercyOne will not routinely waive collection of patient payment responsibilities, i.e. copayments, coinsurance or deductibles. Where necessary and appropriate and consistent with payer rules to the extent they apply, approval may be sought for non-routine discounts or waivers in limited circumstances.  

A. Risk Management Adjustments  
Periodic non-routine adjustments from established fees may be authorized for risk management considerations after consultation with the Director of Quality & Risk Management and after appropriate documentation is completed.
B. Uninsured Patient Discounts
MercyOne will offer a 40% Self Pay discount consistent with the discounts allowed to the weighted average of the three largest managed care payers, or such other similar criteria as established by the Vice President of Finance. In all situations, MercyOne 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 Pay discount may be appealed to and resolved by the Vice President of Finance. The Self Pay discount will not be categorized as Community Care (charity care).

DEFINITIONS:

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

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 payer 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.

Collections Actions – Actions beyond routine statements and telephone calls. Any action that requires reporting to credit agencies and/or legal or judicial process.

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.

Guarantor – The person legally responsible for payment of medical expenses.

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

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 or if issue is non-emergent.
Non-emergent – Patient’s condition does not require immediate medical intervention.

Pre-authorization – Notification to a payer 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 patient/guarantor's home address and may also include letters and telephone contacts to the patient/guarantor’s home phone number and/or other telephone number provided by patient or guarantor.

Referral – The facilitation of authorization of services from one provider to another.

Self-pay Payer – 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.

Payer or Third-party Payer – 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 whom there is no insurance coverage or payment from any third-party payer, and patient is not aware of any other source of payment for the procedure.

Underinsured patient - A patient who has exceeded his/her lifetime maximum for insurance coverage or does not have first dollar coverage for medically necessary healthcare services.

MercyOne Provider – Any MercyOne owned or operated entity furnishing health care services, excluding retail pharmacy and home health providers.