

Billing and Collections Policy

Purpose

- A. To provide a uniform, consistent billing practice for medical services provided by Sioux Center Health.
- B. To provide payment options unique to each patient's financial situation while fulfilling their financial obligation to Sioux Center Health.

Policy

- A. We believe that all persons have a right to medically necessary healthcare and equal access to diagnostic and therapeutic treatment regardless of financial status.
- B. Sioux Center Health shall maintain an open-door policy to provide emergency and medically necessary medical care to the community within the meaning of section 1867 of the Social Security Act (42 U.S.C 1395dd). No limitations or situations for rendering care will be based on the patient's ability to pay.
- C. Sioux Center Health recognizes that certain state and/or federal laws require it to make good-faith efforts to collect all accounts and as such, collection agency services will be utilized in accordance with the standard business industry practice.
- D. The billing and collection practices within this policy are for patients that are not currently in the process of applying for Financial Assistance. For billing and collection practices for Financial Assistance applicants, see the Financial Assistance and Policy. This policy can also be found online at <http://siouxcenterhealth.org/financial-assistance>.
- E. Collection Policy

1. Hospital and Clinic

- a. Per standard procedures, all patients will be asked for proof of insurance at check-in.
- b. Statements are sent after insurance has been processed or after the charges have been produced and the account coded for self-pay patients.
- c. Patients will be encouraged to pay their balance in full before being offered a payment plan.
- d. Balances less than \$9.99 will be written off as small-balance.
- e. Any patient expressing a need or inability to pay will be provided a Financial Assistance Application.
- f. All Patient accounts will be given 120 days from the first post-discharge statement to pay prior to being sent to bad debt. During this time-frame, the patient will receive at least 3 statements and 3 letters.
- g. Payment Plans must adhere to the following guidelines:
 1. One payment plan per event. Event is defined as the time the payment plan is initiated but can merge multiple account balances to be included in the payment plan. If a payment plan is already in place and another event takes place, those will need to be set up on a payment plan.
 2. Balances less than or equal to \$1,200.00 must be paid within 12 months of initial installment payment with minimum and equal payments of \$50.00.
 3. Balances greater than \$1,200.00 must be paid within 18 months of initial installment payment.
 4. Payment arrangements requested outside of 2) & 3) listed above can be extended up to 24 months (for hospital accounts only). These arrangements must be reviewed and approved by the Patient Financial Services Manager.
 5. Payment arrangements requested beyond 24 months must be reviewed and approved by the Chief Financial Officer.
 6. Patients who express not being able to meet these guidelines will be screened by the collectors for the Union Bank Patient Account Financing Program.
 7. Patient Financial Services can also assist patients who would like to apply for Medicaid or other assistance programs.
- h. Patients will be provided an estimate of cost prior to their visit, Patient Financial Services.
 1. For elective, not deemed medically necessary services, the health center will make every effort to collect 100% of the out-of-pocket expense, prior to services being rendered. Should the patient not comply, the service will be canceled until payment in full has been made. Financial assistance is not available for

elective procedures.

2. For hospital patients, Patient Financial Services will link two married adults together upon request to set up a payment plan. Minor children may also be linked to their parents. Adult children (18 or over) will never be linked to their parents.
3. For clinic patients, time of service payment and/or co-pays are to be collected at the time of service. If the co-pay amount is not available, a standard amount of \$75.00 will be collected.

F. Payment Options

1. Cash, check, credit/debit card are all accepted payment types. When a patient calls in to make a credit/debit card payment, we will email them a receipt from the US Bank system.
2. Payment can be made online at <http://siouxcenterhealth.org> and by clicking on "Patients & Guests" and then "Pay your bill."
3. E-banking is set up through American State Bank to withdraw the payment from a checking or savings account. This will be set up on the hospital side and will be set for the date the patient chooses to have it withdrawn.
4. Automatic credit/debit card entered in Waystar to run monthly on the date the patient chooses.

G. Statements and Bad Debt Policy

1. Sioux Center Health will allow all individuals 120 days from the first post-discharge statement to apply for financial assistance before initiating any extraordinary collection activities including placement at a collection agency.
2. If the payment expectations are not met as outlined in E.1. within 30 days of the first post-discharge statement, the account will flow through the collection process as follows:
 - a. After 3 statements with no payment, a pre-collection letter stating the patient has 20 days to contact Sioux Center Health is sent.
 - b. If there is no response on the 20-day letter, another pre-collection letter is sent stating the patient has 10 days to contact Sioux Center Health.
 - c. If there is no contact from the patient, a phone call will be made from Patient Financial Services.
 - d. If there is no success contacting the patient, a final letter is sent stating the patient has 10 days to contact Sioux Center Health, otherwise the account will be sent to the collection agency.
3. Sioux Center Health will refrain from any debt collection practices during an emergency room visit unless the patient has been discharged.
4. All payment options and payment plans are still available during the 120 days after the first post-discharge statement for all patients.
5. When the patient account is turned over to the collection agency:
 - a. The account is flagged as a Bad Debt account.

- b. The account will go through the collection agency's comprehensive system.
 - c. The patient will no longer receive monthly statements from Sioux Center Health.
 - d. The patient is advised to make direct payments to the collection agency.
 - e. When payments are made to the collection agency, Sioux Center Health will receive a check from the collection agency and payment will be applied to the patient's account.
 - f. If payment is made to Sioux Center Health, the collection agency will be notified of the payment amount.
- 6. Sioux Center Health will allow 240 days from the first discharge statement for the patient to apply for financial assistance.
 - a. Patients that return a completed application within the 240 days from the first post-discharge statement, will be suspended from any further Extraordinary Collection Activities and will follow the Financial Assistance Policy for further processing.
 - b. All accounts that qualify for Financial Assistance, according to the Financial Assistance policy, and have Extraordinary Collections Activities will have their account put on hold at the collection agency until the Financial Assistance application has been processed and payments have been made.
- H. Skilled Nursing, Long Term Care, Independent and Assisted Living accounts
 - 1. All residents are required to pay their monthly balance in full within 15 days of receipt of the bill. A 30-day prepayment is required upon admission.
 - 2. All residents will be sent a monthly bill indicating their current and any past due amounts they may owe. Medicaid patients will have a bill that shows their monthly Client Participation amount.
 - 3. After two months of delinquent payment, the account will be referred to the nursing home administrator for review and a plan of action determined and communicated to the Business Office staff as well as the patient or family.
 - 4. Patients who may qualify for Medicaid or who are in the process of applying for Medicaid will be billed for their cost share amounts while their application is pending. This amount would be their income minus \$50.00.
 - 5. Financial Assistance does not apply to skilled and LTC billing.