BAPTIST Medical Park

Surgery Center, L.L.C.

COLLECTIONS PROCEDURES

Baptist Medical Park Surgery Center, LLC set forth a comprehensive collections process. This policy covers billing and collections for self-pay accounts for both uninsured patients and patients with insurance; including co-payments, co-insurance, deductibles and other out of pocket expenses.

The purpose of this policy is to ensure that all reasonable efforts are made to notify patient's in advance (prior to admissions to our facility) of their financial obligation. This allows the patient to make an informed decision regarding their healthcare and financial needs. Furthermore, educate the patient regarding their insurance coverage, out of pocket expenses and how it impacts their financial obligation at our Center.

DEFINITIONS:

ASC: Ambulatory Surgery Center. Baptist Medical Park Surgery Center, LLC is a free standing outpatient facility.

Facility Fee: The ASC bills global feels. Global fee is an "all inclusive" which includes usage of the facility, most drugs, supplies, IV fluids, accessories, equipment, pre-operative and recovery care, personnel and overhead. It excludes the professional fees, some type of implants, anesthesia care, most lab and diagnostics fees and pathology.

Out of Pocket Expense: Expenses for medical care that aren't reimbursed by insurance. May include; deductibles, co-insurance, co-payments for all covered services plus all cost for services not covered.

Covered Services: Medically Necessary Services provided by the Facility.

Medically Necessary Services: Reasonable and necessary services required for the diagnosis or treatment of illness or injury that are performed accordance with recognized standards of care the time of service and that are not primarily for the convenience of the patient or the patient's physician or other health care provider.

Gross Charges: A facility's full, established price for medical care services that the ASC consistently and uniformly charges patients before applying contractual allowances and self-pay discounts.

Contractual Adjustment: is part of a patient's bill that the ASC must write off (not charge for) because of billing agreements with insurance company.

PRE–ADMISSIONS PROCESS

DETERMINING ELIGIBILITY:

The referring provider's office provides the ASC an order for admission which includes the patient demographics, insurance demographics, working diagnosis and planned procedures. Upon receiving the admissions order, the ASC verifies the insurance for eligibility and a specific coverage terms based on information provided and formulates an estimate of patient responsibility.

The ASC Registrars attempts to contact the patient in advance of their estimated patient responsibility along with pre-verification of demographics. After a minimal of two attempts, the registrar refers the call back to the Account Specialist.

In some cases, a letter is sent out to the patient notifying of their patient responsibility. A pre-registration call is made to remind the patient of their financial responsibility along with pre-verification of demographics.

CALCULATING ESTIMATED PATIENT RESPONSIBILITY:

Insured Patients: Individuals with any governmental, commercial, managed care or private health insurance.

The ASC calculates the Center's contractual agreement with the patient's insurance and applies the insurance coverage in order to determine patient responsibility. The calculation is based on what is scheduled by the referring provider. If the patient has additional procedural costs or a more extensive procedure than what is scheduled; may result in additional out of pocket expense to the patient.

The estimated patient responsibility is due in full prior to or day of admissions.

The ASC recognizes that in some cases patients have unexpected expenses, higher out of pocket expenses or limited/excluded coverage and may need temporary financial assistance.

Uninsured Patients: Individuals who do not have governmental, commercial, managed care or private health insurance.

The ASC calculates the Center's gross charges based on what is scheduled by the referring provider and applying the appropriate guidelines for self-pay discount. If the patient has additional procedural costs or a more extensive procedure than what is scheduled; may result in additional out of pocket expense to the patient.

The estimated self-pay patient responsibility is due in full prior to or day of admissions. If the amount is not paid in full; the ASC will null and void the self-pay discount.

POST – ADMISSIONS PROCESS

BILLING PROCESS:

The ASC utilizes an outside vender for certified coding. They review medical records and determine appropriate global billing based on the services rendered during admissions. Records includes but not limited to an Operative Report dictated by the physician, medical history and pathology outcomes

The ASC files primary insurance claims within 3 to 5 days upon discharge of the patient. In addition to filing the primary insurance; the ASC provides a statement of fees/payments associated with medical services provided during admissions within 7 days of discharge.

The ASC does not bill for physician services, anesthesia services, radiology services, lab services and pathology services.

INSURANCE REIMBURSEMENT: (PRIMARY & SECONDARY)

Reimbursement of services provided is expected within 45 days from the date billed.

If a claim is denied, the Revenue Cycle team follows up appropriately. We exhaust all efforts in collecting from the appropriate payers. Such efforts include but not limited to; submitting medical records, corrected claims, re-determinations and written appeals.

If an account is greater than 120 days; the Revenue Cycle designee reports to the Manager of Business Operations for appropriate resolutions of outstanding account. In some cases, the outstanding bill may be dropped to patient.

If patient is unable to pay the additional out of pocket expense applied by their insurance company; financial hardship may be evaluated.

ADDITIONAL SELF-PAY DISCOUNT:

The same self-pay discount guidelines are applied. The calculation is re-adjudicated, payments adjusted and final patient responsibility applied. The Accounts Specialist is responsible for notifying the patient within 5 days after discharge. A final statement of fees/payments associated with medical services provided during admissions within 7 days of discharge. If patient is unable to pay the additional self-pay discount; financial hardship may be evaluated.

SELF-PAY BALANCES AFTER INSURANCE:

Self-Pay balances are incurred due to various reasons. Reasons may include; but not limited to the following:

- Patient's whose balance resulted from having "exhausted benefits" under their insurance plan.
- Patient's whose balance resulted from having "maximum limitations" under their insurance plan.
- Patient's whose balance resulted from having "excluded benefits" under their insurance plan.
- Patient's whose balance resulted from insurance denial due to medically necessary, UCR or investigational under their insurance plan.
- Patient's estimated responsibility prior to admissions is less than what the insurance applied to patient responsibility.
- Patient's whose balance resulted from having "pending additional information" from insured.
- Patient's whose balance resulted from having incorrect co-ordination of benefits.
- Patient's whose balance resulted from non-payment of any mutually agreed upon payment arrangement.
- Patient's whose balance resulted from termination of insurance.
- Patient's whose balance resulted from non-payment of insurance benefits past 120 days.

BAD DEBT:

Prior to categorizing patient account balances as bad debt, the ASC, as part of its routine collections process; mails a series of three patient statements and may make attempts to collect by phone.

In the event of non-payment or the absence of any mutually agreed-upon payment arrangement, the ASC will consider an account to be bad debt and may outsource to third party collections agency for additional attempts to collect.

The ASC's Manager of Business Operations is responsible for determining that the ASC has made reasonable efforts to collect before account is deemed bad debt.

REFUNDS:

In the event there is an overpayment made by the patient; ASC will make all efforts to refund within 45 days of identifying. Refunds are processed the same route as the initial payment which caused overpayment. If the initial payment was process electronically; a refund receipt is mailed to the patient.

References:
Patient Rights and Responsibilities
PR-044 Discounts for Uninsured Patients
PR-048 Financial Assistance Programs for Insured Patients