CHAPTER 17
CREDIT AND COLLECTION

NOTE: Rule making authority cited for the formulation of regulations for the Credit and Collection by the Guam Memorial Hospital, Chapter 80, Title 10, Guam Code Annotated.

§17101. Credit and Collection Section. (a) **Purpose.** The Credit and Collections Section acts as the Hospital's financial arm in dealing with patients and/or their families and/or guarantors in securing payment of account balances and evaluating their ability to pay.

(b) **Responsibility.** In order to achieve this objective, the Credit and Collections Section will notify the patients or their representatives of hospital account balances and will attempt to obtain payments by means of telephone reminder, and correspondence. They shall exercise discretion and judgment in making financial arrangements based on information received.

§17102. Purpose. To assure that effective policies and basic procedures are consistently followed during the registration, billing and collection of patient revenues, the following policy and procedure statements are established to provide clear policy direction to those responsible for the collection of fees for services rendered by the Hospital.

§17103. Policy. Guam Memorial Hospital Authority is a community characterized by mutual respect, common goals and shared responsibilities. The Hospital believes that the concept of shared responsibility extends to each patient an obligation to take care of his/her hospital bill to the best of his/her ability. Proper and standard business practices will be applied to responsible parties who are delinquent in paying their accounts.

The Hospital will not deny access to emergency medical care to anyone based on their resources or ability to pay for care. The payment guidelines set forth in these policies and basic procedures are used as guidelines. They have been written in order to give Fiscal Services representatives some working tools to negotiate a fair payment effort from each individual. Any time an individual appears to have inadequate resources to settle their hospital bills in full, Fiscal Services representative will

work with the patient/representative to obtain payments based on their financial capabilities.

§17104. Procedures. (a) **Billing and Collection Basic Procedures.**

(1) All patients, regardless of health insurance coverage or other considerations, shall be charged for services received on the basis of the Hospital's fee schedule. Fees for professional services will be determined by the appropriate physician and will be billed separately from the Hospital's fees for supplies and services except for house cases.

(2) All patient bills are due and payable at the time that services are received.

(3) Patients are regarded as having the responsibility for the costs of their care. Insurance billing on behalf of the patient is provided as a courtesy service to the patient and does not relieve the patient of responsibility for the account. Assignment of payment responsibility to an insurance company does not relieve a patient of their responsibility for payment for services received.

(4) It is the responsibility of the Patient Affairs Division (Business Office) of the Hospital to bill patients, responsible parties, and Third-Party Payers promptly, to institute a vigorous follow-up of all unpaid accounts receivable and to ensure that payments are received from whatever source the Hospital may legally seek for payment.

(5) When the term *Patient* is used in the policies and procedures, it means the patient, the patient's immediate family, or the persons responsible for the payment of the patient's bill, otherwise known as Guarantor.

(6) Accounts deemed to be uncollectible by the Patient Affairs Division (Business Office) may be assigned to a collection attorney or agency in accordance with these policies. Patients will be liable for additional sums due as a result of collection costs.

(b) **Basic Credit Policies.**

(1) **Inpatient and Outpatient.** It is the Hospital's policy that payment for all services shall be due and payable at the time services are rendered. Except for services covered by Third-Party Payers, all accounts

are considered cash accounts. The Hospital will honor the assignment of financial liability to a Third-Party Payor based on the patient's ability to provide evidence of current coverage by such a payor provided that the Third-Party Payor is recognized by the Hospital and is in good standing with the Hospital.

Assignment does not relieve the patient of his/her obligation to pay as the Third-Party Payor may for some reason or another reject in whole or in part portion of the bill due to the Hospital. The patient will be required to pay applicable deductibles or co-payments at the time of service.

(A) Emergency admissions shall be reviewed daily for medical coverage. If no coverage exists, the patient, or his/her responsible party shall be contacted to make financial arrangements.

(B) It shall be the responsibility of Patient Service Representatives to assist patients with the completion of the admitting forms. They should obtain the necessary signatures, contact and policy numbers, Medicare, Medicaid, MIP, and welfare numbers and any other information necessary to properly process the patient's claim. Patients must present his/her identification card and sign the necessary insurance forms.

If adequate information is not provided by the patient, non- emergency diagnostic services may be delayed or the patients will be subjected to the Hospital's self-pay policies.

The only exception to this policy is if the patient has forgotten his/her identification card and phone verification of coverage is obtainable.

The patient may telephone the information to the Hospital within 24 hours if phone verification is not possible, but they must sign a payment agreement until the necessary information is received. Other self-pay patients are expected to pay their outpatient bills as soon as services have been received.

If the patient has insurance covering outpatient services that is not on the hospital-approved list, the patient may bill the insurance

carrier himself/herself for reimbursement after he/she pays the hospital bill.

(C) In any situation in which the patient and/or responsible party refuses to cooperate with or becomes irate with the Patient Service Representative, they are to be immediately referred to the Patient Service Supervisor on duty or the Chief of Admissions.

(D) While hospitalized, third-party coverage will be verified and/or accepted. The patient shall be notified while in the Hospital if his/her insurance coverage is not sufficient to cover the full amount of his/her bill. Contact is subject to patient's medical and mental condition. The Patient Service Representative will coordinate with the head nurse responsible for the nursing unit before approaching the patient with the interim bill. If the head nurse determines that the patient should not be contacted, it will be noted on the patient's account on the computer system, and the Patient Affairs Division will be notified. Follow-up contact will again be verified through the head nurse. If a physician does not want the patient to be contacted about financial matters, he/she may indicate this in the patient's record.

If the patient is hospitalized for more than ten (10) days, he/she will receive a bill requesting payment of his/her portion of the account. This bill will be handled by an employee of the Patient Affairs Division and discussed with the patient.

Third-party payers are not sent billing prior to patient's discharge except in cases of extended stay and as required by regulations.

(E) Upon being discharged, an interim bill summarizing all charges keyed in up to time of discharge shall be presented to patient/guarantor for payment. If patient is unable to pay the interim bill, payment shall be sought from the guarantor.

(F) Credit arrangements will be documented in the patient's folder. The patient will then receive from Patient Affairs Division, a computer statement of his/her account every thirty (30) days. These monthly statements consist of a

delinquent notice at thirty (30) days, a second notice at sixty (60) days, a third notice at ninety (90) days, and a final notice at one hundred twenty (120) days.

(G) If patient/guarantor is a Government of Guam employee, he/she will be encouraged to sign a Payroll Deduction form authorizing monthly deductions to cover a personal account when there is:

1. No insurance coverage; and/or

2. An existing balance for services rendered outside of the scope of insurance coverage after insurance company has paid.

(H) Should patient dispute any charges of his/her bill, the Patient Service Representative will refer the patient to his/her Supervisor who will look into the problem immediately. If the dispute is not resolved through this means, the Supervisor shall inform the patient that the concerns will be documented and brought up to the Patient Affairs Division who in turn will forward copies of patient's bill and related documents and concerns to the Quality Management Department. The patient must be told that the Hospital will provide feedback on his/her concerns by the Patient Affairs Division.

(I) Once an account becomes delinquent or inactive, the Credit and Collections representative will make telephone calls to the patient to determine when payment can be expected or if a problem exists with the account.

(J) If the telephone calls do not reactivate the account and result in a payment, a "final notice" will be sent to the patient stating that the account will be reviewed and processed for further collection action if payment is not received within ten days.

(K) Each month, those accounts which received a "final notice" but have not responded will be reviewed and processed for further collection action via collection agencies or attorneys. Patients will be liable for the payment of collection costs in addition to their unpaid hospital bills.

(L) The Hospital may elect to work with the Department of Revenue and Taxation to withhold income tax refunds for outstanding patient accounts at the Hospital.

(2) **Outpatients on Continuous Treatment.**

(A) These patients will be billed on a monthly basis.

(B) Payment is expected within fifteen (15) days from billing date.

(C) If the account becomes delinquent, the Credit and Collections staff will contact the patient to make arrangements so that the services may be continued.

(3) **Pre-Admission:**

(A) Pre-admission forms will be distributed to all the physicians on the Medical Staff.

(B) When a Pre-Admission Registration is received by the Hospital, the Patient Registration Division will provide the patient with the following information:

1. Instruction and information on the admission process; and

2. Information on the Hospital's Credit and Collection Policies.

(C) The patient must make every effort to understand and arrange for his/her financial obligation to be met so that he/she can provide information on his/her ability to meet this obligation prior to or at the time he/she is admitted to the Hospital.

(D) A Patient Registration staff will review all pre-admission information in an attempt to identify and resolve any payment problems prior to admission. Should the patient have no insurance coverage and after finding out information regarding employment status, the Patient Service Representative shall request the patient to sign an Acknowledgement of Responsibility form. This form states that the patient received instructions from the Hospital that the patient is to obtain a temporary Medicaid or M.I.P. card for the hospital services to be

rendered. The form further authorizes the Department of Public Health and Social Services (DPHSS) to release any information to the Hospital pertaining to patient's eligibility. This form is forwarded to DPHSS for processing.

(E) Normally, Patient Registration staff will, through the information submitted, assign a financial class to establish the payment plan applicable to the patient's individual circumstances.

(F) Patients who appear to have payment problems will be contacted to verify what arrangements can be made for the payment of their pending obligation.

(G) For Self-Pay patients seeking elective surgeries, it is the responsibility of the Patient Service Representative to inform the patient of the deposit program. A deposit of $250 shall be required.

(H) If the patient does not have sufficient funds to pay the deposit, it is possible at this point either to:

1. Have the patient arrange for payment of his/her obligation based upon one of the Hospital's payment plans, payroll deduction or payment agreement; or

2. Have the patient complete an application for financial assistance under either federal or local medical assistance payment programs.

(I) A patient's account will be immediately referred by the Business Office to a collection attorney or agency if the patient refuses to make full payment on their account, or if the patient refuses to:

1. Apply for extended payment; and

2. Apply for financial assistance.

(J) If the patient makes a deposit, the Patient Registration staff must forward to the Cashier a receipt noting the amount the patient made as a deposit.

(K) All deposits will be credited towards payment of the account. Any remaining balance shall be refunded to the patient within 30 days.

(4) **Admissions Procedure.**

(A) All patients are assigned to a financial class when they are admitted to the Hospital.

(B) When a patient is admitted to the Hospital, Patient Registration will have typed an Admission and Discharge Record listing the required personal and payment data.

(C) The financial agreement section of the Admission and Discharge Record must be signed by the patient.

(D) If the patient has insurance or is covered under one of the government health care programs, the Patient Service Representative will:

1. Verify the patient's insurance or Federal aid identification card; and

2. Have the patient sign the assignments and authorizations for billing.

(E) Patients who are required to make a deposit at admission will be directed to the discharge area for payment.

(F) The Hospital's credit policy will be presented to the patient at the time of admission.

(G) The Patient Service Representative should explain that, unless insurance benefits are sufficient to cover hospital expenses, the terms are cash at the time of discharge.

(H) In emergency situations where the patient bypasses the Patient Service Representative, an Admission and Discharge Record will be completed by the Patient Service Representative as soon as possible after admission.

(I) The Chief of Admissions will review all Admissions and Discharge Records the next morning and assign tentative payment plans for each.

(J) If there is insufficient information to make a tentative assignment, the Patient Service Representative will obtain the additional required information from the patient.

(K) If it is requested by the patient or anticipated by the Patient Service Representative that the patient will need financial assistance, the Patient Service Representative will arrange for an application to be completed prior to discharge.

(5) **Patients with Third-Party Coverage.**

(A) The Hospital accepts insurance assignments. The patient is responsible for identifying the benefits program of coverage. The Hospital will work with assigned Third-Party Payers to achieve proper coordination of benefits.

(B) Patient Service Representatives will verify insurance coverage with the Third-Party Payor within 24 hours of admission.

(C) Assignment of Benefits - In order to recognize Third-Party coverage, all patients or their legal representatives are required to sign an assignment of benefits statement prior to the provision of services. If Third-Party insurance has been identified but the patient refuses to sign the assignment statement, the patient becomes subject to the Hospital's self-pay policies.

(D) If it is determined that the patient has full medical and surgical coverage and has assigned benefits, credit will be extended on the account.

(E) If it has been determined that the patient does not have full medical and surgical coverage and/or the deductible has not been met, the Patient Service Representative will contact the patient and/or member of the family within 24 hours of this determination. Payment of the deductible and/or co-payments must be made at the time of discharge.

(F) If a patient does not assign his/her insurance benefits or has an estimated benefit after insurance coverage, the Patient Service Representative will advise the patient and/or family that payment or satisfactory arrangements for payment must be made at the time of discharge.

(6) **Uninsured Parties Receiving Non-Emergency Hospital and Medical Services.**

(A) Uninsured patients are required to pay a deposit of $250 on or before admission for elective surgeries. Satisfactory arrangements for payment of the balance of the hospital charges are to be made with the Patient Service Representative and/or Credit and Collections staff.

(B) Should an uninsured patient be admitted without making a deposit; i.e., maternity patient or patient who is determined not to be insured after admission, the Patient Service Representative will contact the patient and/or the responsible party within 24 hours after admission or as soon as medically possible to make the necessary financial arrangements for the payment of the hospital charges.

(C) Should an uninsured patient be unable to pay the balance at discharge, necessary credit arrangements must be made with the Patient Service Representative and/or Credit and Collections staff.

(7) **Patients with Previous History of Credit Problems.**

(A) The Guam Memorial Hospital Authority will render emergency medical services to all patients regardless of their ability to pay. Emergency admissions will be certified by the admitting physician on the patient's chart. As soon as possible after the medical emergency has been resolved, the Patient Service Representative will contact the patient and/or responsible party to make arrangements for payment of the hospital charges.

(B) Non-emergency cases will be interviewed by the Patient Service Representative prior to admission. A deposit of $250 from self pay patients is required for elective surgeries. All other services must be paid upon discharge.

(8) **Workers' Compensation, Accident and Personal Injury Admissions.**

(A) Worker's Compensation cases are treated the same as insured patients. Patient Service Representatives will verify employment, liability, and benefits on all Worker's Compensation cases within 24 hours after admission.

(B) Regardless of the presence of Worker's Compensation coverage, all charges remain the primary responsibility of the patient.

(C) Automobile accident cases and personal injury cases that may go to litigation are admitted subject to the procedures outlined above. The Patient Service Representative will contact the patient as soon as medically practical to advise him/her that he/she is personally responsible for his/her hospital charges, and that these charges are due and payable at discharge. The Hospital cannot agree to delay payment until a legal settlement is made.

(D) All contested Worker's Compensation and accident liability cases will be handled as Self-Pay accounts.

(9) **Medicaid Patients.** Guam Memorial Hospital Authority will provide application assistance to patients who may be eligible for Medicaid and other federally funded programs but who have not filed for benefits. Eligibility determinations are made by the Department of Public Health and Social Services.

(10) **Medically Indigent Program**.

(A) The Patient Service Representative and/or Social Worker will interview the patient and/or responsible party to determine if the patient qualifies for available assistance. The Patient Service Representative and/or Social Worker will help the patient and/or responsible party obtain this assistance. If it has been determined by the Department of Public Health and Social Services that the patient does not qualify for any public assistance and the patient is unable to meet his/her financial obligation, the Credit and Collection staff will assist in making arrangements for extended payments or other financial assistance.

(B) The Patient Service Representative will complete the above procedures. Emergency patients are treated and admitted if necessary.

(11) **Credit Policies at Discharge - Inpatients with Third-Party Coverage.**

(A) Patients are asked by the Cashier, Patient Service Representative or a representative of the

Patient Affairs (Business Office) to pay their portion of the account in full upon discharge. If the patient is unable to pay his/her portion, payment arrangements on any balance less than $100.00 and for a period up to 30 days may be arranged by the Cashier, Patient Service Representative or a representative of Patient Affairs (Business Office). In accordance with the policy on discharging the patient, all other cases are referred to the Credit and Collections staff.

(B) Patients are to be informed by the Cashier, Patient Service Representative or a representative from Patient Affairs (Business Office) that the Hospital will process their portion of the claim to the Third-Party Payor and that it is up to the patients to see that all necessary information is sent to the carrier involved. Patients shall be informed that in the event that their Third-Party Payor does not pay the claim within 120 days, they will be billed for the total balance. Additionally, they shall be informed that the Hospital's estimate of the third-party liability is only an estimate and not a guarantee of payment. Denied or rejected charges by Third -Party Payers shall not be billed to the patient unless the charges are for non covered benefits, deductibles, co-payments, or returned for primary insurer. Denied or rejected charges shall be written off.

(C) Patients are to be informed by the Cashier, Patient Service Representative or a representative of Patient Affairs (Business Office) that they will receive an itemized statement of their hospital charges in approximately ten (10) to twenty (20) days after discharge. The Hospital will also send a copy of the same itemized statement directly to the insurance company involved.

(D) Once an account has been paid by a Third-Party Payor and there is secondary insurance, or once all insurance companies have paid and an account has been determined to be private or self-pay for any balance owing, the following procedures/guidelines should be adhered to for collection of the account:

Credit arrangements will be documented in the patient's folder. The patient will then receive a computer statement of his/her account every thirty (30) days. These monthly statements consist of a delinquent notice at thirty (30) days, a second notice at sixty (60) days, a third notice at ninety (90) days, and a final notice at one hundred twenty (120) days. If no payment is made after a final notice and after telephone calls are made, the account shall be referred to a collection attorney or agency. The collection costs shall be borne by the patient.

(12) **Discharge Procedures.**

(A) All patients are cleared through the Credit and Collections Office prior to discharge to ascertain if:

1. The bill is paid; or

2. Arrangements for payment have been completed.

(B) As payment in full is due at discharge, the patient will be asked to make the payment at this time. Payments should be based on the balance due on their account. The patient should be advised that the Interim Bill which is generated upon discharge may not be complete. Additional charges may be added later. The patient must be advised that a final bill with all charges will be mailed to him/her ten (10) to twenty (20) days after discharge.

(C) If the terms call for extended payments, the Patient Service Representative or Credit and Collections staff must have the patient and/or guarantor sign the necessary Payment Agreement or Payroll Deduction form.

(D) It is very important that the patient understand the terms of his/her payment plan.

(E) He/she must be informed of:

1. The billing procedures; and

2. Additional charge(s) that may be added to his/her bill.

(F) The patient must be informed that the account may be turned over to a collection

attorney or agency if not paid within one hundred twenty (120) days, and that he/she will be liable for collection costs as well. Furthermore, the patient must:

1. Agree to terms at time of discharge; and

2. Sign the necessary Promissory Note.

(c) **Terms and Conditions Form.** For both inpatient and outpatient services, the patient is provided a **Terms and Conditions** Form to sign. Specific areas explain the following:

(1) **Authorization or Medical Treatment.** By signing this section, the patient is authorizing the physician to administer medical services to the patient.

(2) **Release of Information.** The patient is authorizing the Hospital to disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the Hospital or to a family member or employer of the patient for all or part of the Hospital's charge, including, but not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

(3) **Assignment of Insurance Benefits.** This section assigns hospital benefits the patient may have under his/her insurance coverage to the Hospital for application on patient's bill. The assignment of such benefits shall in no way obligate the Hospital to delay or relinquish its demand for direct payment from the patient for any of the outstanding balance.

(4) **Patient Responsibility.** Any services/medications ordered by the patient's attending physician and not paid by patient's insurance company shall be the direct responsibility of the patient.

(5) **Financial Agreement.** The person who signs this Form, either as patient or agent, agrees that in consideration for the services received, the person individually obligates himsel00f to:

Pay to the Hospital, within thirty (30) days of bill date, the amount or amounts due as evidenced by the patient's account for services rendered plus reasonable attorney and/or

collection agent fees and court costs if referred to an attorney and/or collection agent.

The person who signs this Form agrees that any amount not paid in accordance with the above financial agreement shall be considered past due.

(6) **Release from Responsibility.** Once signed, this certifies that the patient is leaving the Hospital against the advice of attending physician and of Hospital Administration. The patient has been made aware of the risk involved and releases the attending physician and the Hospital from all responsibility for any ill effects which may result from such discharge.

(d) **Accounts Referred to a Collection Attorney or Agency.**

(1) Accounts delinquent after one hundred twenty (120) days shall be referred to a collection attorney or agency for further action. The Hospital shall pay the collection attorney or agency a one-time referral fee as established in the collection services agreement.

(2) The collection attorney or agency shall collect all fees and costs from the patients directly in addition to the delinquent amount of the Hospital bill.

(3) The Hospital has the authority to recall accounts from the collection attorney or agency for the following reasons:

(A) Patient eventually qualifying for any of the government sponsored medical insurance programs;

(B) Patient's willingness to work with the Hospital and not with the collection attorney or agency. This also covers direct payments received by the Hospital from the patient; and/or

(C) Hospital referred the account in error to the collection attorney or agency.

(4) The hierarchy of approval to recall accounts once referred are as follows:

(A) Board of Trustees - over $4,000.00

(B) Hospital Administrator - more than $2,000.00 but less than $4,000.00.

(C) Hospital Comptroller - more than $1,000.00 but less than $2,000.00.

(D) Business Office Manager - up to $1,000.00.

(e) **Handling of Unpaid Hospital Accounts of Deceased Patients.**

(1) The Credit and Collection Division shall review the Hospital account of a deceased patient to ascertain whether all charges and payments have been keyed into the system.

(2) Once the account has been reviewed, the account shall be referred to a collection attorney or agency for further action.

(3) The attorney or agency shall make all attempts to contact the family to settle the outstanding bill. The attorney or agency shall keep the Hospital informed of its actions.

(f) **Processing a Refund on Overpayment.**

(1) In the event an overpayment is discovered on an invoice, the following steps must be taken:

(A) If the overpayment was made by an insurance company, the Patient Affairs Division must contact the insurance company for disposition of the overpayment. Disposition can be either a refund of the amount or to have the overpayment applied to another invoice under the patient's name.

(B) If the overpayment was made by the patient, such overpayment must be applied to other outstanding patient share balances owing on other invoices. If there are none, the overpayment must be applied to other accounts wherein the patient is a guarantor. This must be appropriately coded in the patient's account to show a proper audit trail. Furthermore, the Patient Affairs Division must inform the patient of such action via a letter. A copy of such letter must be kept in the patient's file.

(C) In the event the overpayment was made by the patient and his insurance company still has not paid its share, such refund cannot be processed until payment is received from the insurance company to satisfy its share.

(D) If it has been determined that patient owes nothing more, his insurance company owes

nothing more and the patient is not a guarantor to another account, the patient is due a refund.

(E) A refund is to be requested through a Refund Request form initiated by the Patient Affairs Office and is forwarded to Accounting Department for payment processing. The Accounting Department will route the payment to the address given on the request form.

(g) **Write-Off Policy.**

(1) The Patient Affairs Division shall exhaust all efforts in collecting an account as described herein.

(2) Denials made by Third-Party Payers shall be analyzed monthly and forwarded to Medical Records to retrieve missing documents and for Full Chart Reviews, and to Utilization Management to verify excessive and inclusive charges. All results shall be forwarded to the Business Office Manager for further disposition. (Either for re-billing or proposed write- off action.)

(3) Once all efforts have been exhausted and all applicable statutes of limitation have run, the Business Office Manager shall forward a request to the Hospital Comptroller recommending write-off of an account.

(4) Write-offs may be recommended for the following reasons:

(A) Account is considered a true bad debt despite all collection efforts made;

(B) Hospital billed charges in error based on findings by Quality Management Department;

(C) Hospital billed charges beyond statute of limitations per Federal regulations (concerning Federal programs);

(D) Hospital billed charges beyond statute of limitations per written agreement between the Hospital and the Payor;

(E) Contractual Allowances;

(F) Account balances $5.00 and less;

(G) Receipt of a Bankruptcy Notice regarding a patient; and/or

(H) Upon recommendation from the Collection Attorney/Agency;

(5) Write-offs shall be approved as follows:

Approval Hierarchy:

(A) The Business Office Manager may authorize write-offs less than $5.00 per account.

(B) The Hospital Comptroller may authorize write-offs less than $2,000.00 per account.

(C) The Hospital Administrator may authorize write-offs less then $5,000.00 per account.

(D) The Planning and Finance Committee of the Board of Trustees may authorize write-offs greater than $5,000.00 per account.

(6) A list of all write-offs will be prepared by the Hospital Comptroller for approval by the Board of Trustees.

The approved resolution and write-offs listing will then be forwarded to the Attorney General of Guam for his/her approval in accordance with the local statute.

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