

## **Admissions**

### **Why do I have multiple account numbers?**

Each time you present for a new medical service, a new account number will be assigned.

### **I gave the hospital my insurance card last time I was at the hospital. Why isn't it on this account?**

You must present your current insurance card and picture identification at each new medical service. A copy will be made and kept in your patient folder for that visit. If you do not give insurance information at the time of service, your claim may be denied for timely filing or no authorization and may be your responsibility to pay.

### **Why wasn't I told at the time of service that my insurance was out-of-network?**

Insurance networks and their contracts change frequently; it is always advisable that you check with your insurance provider directly for the most current list of in network providers.

## **Anesthesiologist**

### **The anesthesiologist that was assigned to my surgery was not in-network for my insurance plan. Why did the hospital assign a physician that was not on the same plan as the hospital?**

The hospital does try to encourage all physician groups to contract with the same insurance networks that the hospital contracts with. Selection of the anesthesiologist is done by your physician and/or surgeon and is the physician's preference. Most anesthesiologist groups will work with you to match your in-network rates if they were not contracted. Please contact them directly to inquire about this.

## **Attorney Calls**

### **How can I get a discount for accident related services?**

If the attorney phone call pertains to injuries the patient sustained in an accident, then ask the caller to complete the Third Party Disclosure Form. This form is designed for the attorney to complete in order to disclose relevant details. Form is available under PPRC/Support Services- Legal/DAL.FT.LGL.6014 Liability Disclosure Form. The law office must fax this form to the Legal Unit at 1-800-561-1743 for review.

### **How can I get a copy of my client's bill?**

To request billing records, please mail your request with a HIPAA compliant release of information signed by the patient to Dallas Shared Services c/o Legal Dept Atty Requests 10030 N. MacArthur Blvd. Suite 100 Irving, TX 75063 or fax to 1-877-801-2861. For status of requests submitted after 4/12/10 please contact HealthPort at 1-469-420-7190. Be sure to record the name of the law firm and the phone number of the law firm (or insurance adjuster if applicable) in the ARTIVA insurance screen and notes for future follow-up by the Legal Unit.

## **Auto Insurance**

### **My auto insurance or the driver of the other car that caused my auto accident is responsible for the bill.**

- For Texas and Oklahoma, we must bill your healthcare insurance first unless you have Medicare.
- For Kansas, the patient must provide his PIP coverage (Personal Injury Protection automobile coverage which is a no fault coverage) so that the PIP coverage may be billed first. In Kansas, PIP coverage is always the primary payer. Health insurance will not pay on the claim without proof that the PIP Benefits have been exhausted and paid on accident related medical bills. Obtain patient's PIP coverage information so that we may bill the PIP Carrier.

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- Before Medicare can be billed, we must obtain information about all available automobile or liability insurance information. For a period of 120 days from date of service such automobile or liability coverage is considered primary to Medicare and must be billed.

If you do not have any healthcare coverage, we will bill your auto insurance but you will be ultimately responsible for the bill. In order to file a claim against liability insurance, we must file a hospital lien against the liability insurance policy. **Action:** Complete the TPL MVA Screening form located in the Support Services – Legal folder, mail to the patient with instructions for them to complete and return to the PAS. Collection efforts will not discontinue and billing of claim to auto insurance will not be done until all information is verified and the claim is expected to pay. Notate all information obtained in the Artiva including location and details of accident, name of the party who was at fault, other drivers insurance name, claim number, adjusters name and phone number. Be sure and note the identity of any insurance carrier, insurance adjuster along with phone number and claim number in the notes in ARTIVA for future reference.

**Can the hospital file a lien for Medicare accounts?**

The Centers of Medicare and Medicaid Services follow primary and secondary payer regulations. When Medicare is the secondary payer, it is not obligated to pay for services and items that a primary provider has to fund. The secondary payer regulations protect Medicare from payments outside its responsibility. Medicare payment will be secondary (or excluded) when the following types of insurance are available to cover health care costs:

Workers' compensation;

Automobile, no-fault, or liability insurance; OR Employer group health plans

If an injured Medicare beneficiary's medical expenses are covered by liability insurance, (including self-insurance, no-fault and med-pay insurances), Medicare will pay for medical services only when the third-party insurance payment will not be "prompt." {42 USC Section 1395y(b)(5)}. Applicable regulations are found at 42 CFR Part 411 (1990). Such Medicare payments are described as "conditional" and the program expects to recover them when the private insurance payment "has been or could be made." For a period of 120 days from date of discharge or date of service, the medical provider is expected to recover payment for services rendered to the patient, from liability insurance, med pay insurance, personal injury protection insurance or underinsured motorist insurance. ("Prompt" is defined as within 120 days of the earlier of the date of an insurance claim or the date of medical service. 42 C.F.R. § 411.50(b)). Regulations further provide that the medical provider is to follow state law in the process of making a claim against such sources of insurance. In Texas, state law provides that the hospital may file what is known as a hospital lien, as a means of making a claim against liability insurance.

A hospital can choose not to bill Medicare but to instead bill a liability insurer (by asserting a statutory lien on the beneficiary's insurance settlement). SEE Medicare Program: Third Party Liability Insurance Regulations, 68 Fed. Reg. 43940 (2003), modifying 42 C.F.R. 411.54 and 489.20.

- 1. Question: For Texas accounts, does Texas Law (Tex. Civ. Prac. & Rem. Code § 146.001, 146.002 and 146.003 (2000)) prohibit the PAS from conducting Medicare secondary payer investigations? To put it another way, does Texas State law require that providers file a claim to Medicare rather than seek payment from automobile insurance resources?**

Answer: Federal law would take precedence over the state law. In any event, Texas law does coincide with the 120 day timely period under the Medicare regulations, a time during which the medical provider is expected to seek payment from automobile insurance which is primary to Medicare. The Texas law would require the provider to make an election to bill Medicare by the first day of the 11th month after the date services are provided. We strive to file to Medicare before the account ages to that degree.

§ 146.002. TIMELY BILLING REQUIRED.

(c) If the health care service provider is required or authorized to directly bill a third party payor operating under federal or state law, including Medicare and the state Medicaid program, the health care service provider shall bill the third party payor not later than:

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- (1) the date required under any contract between the health care service provider and the third party payor or the date required by federal regulation or state rule, as applicable; or
  - (2) if there is no contract between the health care service provider and the third party payor and there is no applicable federal regulation or state rule, the first day of the 11th month after the date the services are provided.
2. Under Federal law, medical providers are required to collect from primary insurance sources for a period of at least 120 days from date of discharge. Please note that under Federal law, automobile insurance is considered to be primary to Medicare. Medicare is a secondary payer when no fault auto insurance, third party liability insurance or uninsured motorist coverage is involved. Per 42 U.S.C. 1395y (b) (2) and 1862(b) 92) (A) (ii) of the Act, Medicare is precluded from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under an automobile or liability insurance policy."

Medicare is the secondary payer when a person has other insurance that is required, by law, to pay its benefits before Medicare. Medicare is secondary to group employer health plans, no-fault insurance, liability insurance and workers compensation.

Per 42 USC 1395y (b) (2) (Section 1862(b) (2) (A) of the Social Security Act), Medicare is precluded from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made promptly...under a Workers' Compensation plan, automobile or liability insurance policy or plan (including a self-insured plan) or under no fault-insurance". Medicare may make conditional payments for Medicare covered services that the third party payer does not pay promptly conditioned on reimbursement to Medicare from proceeds received pursuant to a third party liability settlement, award, judgment, or recovery. For all the above reasons, our office does seek information pertaining to an accident victim's med pay, PIP, liability and or uninsured motorist coverage in order to pursue payment from such primary resources during the period of 120 days from date of service as required under the Federal Medicare Secondary Payer regulations. Please feel free to contact the Medicare Coordination of Benefits contractor for further information.

IF a hospital or other medical provider does not receive payment promptly (promptly by definition means 120 days from date of discharge) from a third party insurer it has billed in a liability, no-fault, or workers compensation situation, it may bill Medicare for conditional payment. If the provider bills Medicare, it must withdraw all claims with the third party payer in liens against any settlement, judgment, or award for those services.

The Federal Government has issued explanatory regulations for these provisions at:

- 42 CFR 411.20 Basis and scope, Statutory basis (a) (2)
- 42 CFR 411.24 Recovery of conditional payments.
- 42 CFR 411.26 Subrogation and right to intervene.
- 42 CFR 411.50 General Provisions.
- 42 CFR 411.52 Basis for conditional Medicare payments in liability cases.
- 42 CFR 411.53 Basis for conditional Medicare payments in no-fault cases.

## **Bankruptcy**

### ***I have filed bankruptcy, why are you billing me?***

Obtain the case# and date filed. Using the Action Code for Bankruptcy, place the account in Bankruptcy Bad Debt status. If the case# and date filed is not available please have the patient fax the Notice of Bankruptcy Filing and/or Court issued discharge of debt to 1-800-561-1743. If the patient is not able to fax the notice, make notes on the account and place in Estate/Bankruptcy Pool for follow up and cancel from all agencies except B-Line.

## **Billing**

### **My insurance company said they do not have a claim on file for my account.**

A hospital claim is most often sent electronically to your insurance company after discharge. If your insurance company does not accept electronic claims, a paper claim is mailed to them. Your insurance company will be billed for the total charges of the services. **Action:** Verify that **all** insurance information is correct including name of insurance, address, policy numbers, policy holder, etc. Correct any invalid or incomplete information in Artiva and submit rebill request.

### **I do not have insurance, when will I get a bill?**

You will get a statement as soon as the bill is final. If you do not pay within 14 days, your account will be referred to our National Patient Account Services. **Action:** Offer to accept a payment on the existing balance or make payment arrangements and place with the account with NPAS.

### **Why did I get a bill from “Radiologist, Pathologist, Anesthesiologist and ER Physician?”**

During your visit to the hospital, your doctor may order of tests, procedures and/or other services. Many of these services are performed by physicians who work in the hospital and bill for their services separately. After your visit, you may receive bills from the physician, surgeon, pathologist, radiologist and anesthesiologist. For questions regarding these bills, please call the number listed on the bill.

**Action:** Offer the caller the name and phone number of the provider if they do not have it. The listing is located on the Dallas SSC website Facilities

### **How can I get a copy of my detail bill?**

I can provide a copy of your detail bill but for future reference, you may request this through the interactive voice response (IVR) system and should be processed within 2 business day. You may also view and print a summary of your charges from the hospital’s website under Bill Payment and Inquiry. Please have your account number, patient social security number and date of birth. **Action:** Verify callers address; print the most recent bill from DEL, email, fax or mail in a window envelope. Reference P&P available on Dallas SSC Website under PPRC/Support Services-Customer Service/References DAL.REF.SS.0012 Procedure to request a patient statement or detail bill.

### **When will my secondary insurance be billed?**

Your primary insurance must either pay or deny your claim before your secondary insurance can be billed.

## **Charity**

### **How can I find out if I qualify for Financial Assistance or Charity?**

Our hospital has a Charity Discount Policy that provides free hospital care for patients who have received emergency care, do not meet qualifications for Medicaid and whose income is less than 200% of the Federal Poverty Level. In order to be considered for this program, you must complete a Financial Assistance Application and provide supporting income documentation for income verification purposes.

### **Action:**

- 1) Customer Service to send patient(s) a FAA when Charity is secondary to Primary Insurance:
  - a. ER or ER Admission
  - b. No patient payment
  - c. Primary Insurance with a co-pay greater than \$1,000.00
  - d. Add 9950 Charity Pending IPlan and prorate money
  - e. Inform patient that they have 14 days to complete, attach supporting documentation and return FAA
  
- 2) Customer Service to send patient(s) a FAA when patient states that they **did not** receive a FAA at the facility:
  - a. Patient **must** call Customer Service within 14 days of receipt the initial Charity denial letter
  - b. Add 9950 Charity Pending IPlan to the account and prorate the money

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**Action:** Review previous notes to determine if charity has already been offered and the patient did not return the FAA or necessary supporting income and household size documentation, did not qualify or was denied. If there are no notes indicating that Charity was offered, print a Financial Assistance Application, mail to the patient and document the account.

**What are supporting income verification documents?**

The Charity Program requires the current year's Federal Tax Return (Form 1040) or 2 (two) of the following: Employer Pay Stub, Written documentation from Income Source (W-2, Food Stamp Approval Letter, SSI, SSDI, Pension Letter, Annuity Letter, etc.), Bank Statement.

**How long does it take for my account to be reviewed for Charity?**

If all the required supporting documentation is received, the review should take no more than 10 - 14 days.

- OUMC - Check Meditech to verify Coverage Dates have been updated and/or current.
- If Faxed and it has been more than 7 days (one week) and no notes in Meditech, have the patient re-fax to Charity Department (877) 685-0593.
- If mailed and it has been more than 30 days and no notes in Meditech and/or Artiva, have patient re-mail or Fax to Charity Department.

**What is the status of my charity application?**

**Action:** Look in Artiva to see if an application and/or supporting income documentation has been received. If there are no notes on the account indicating that a FAA has been received, tell the patient we have not received it yet and to allow 14 days. If there are not notes stating financial application received, review reason for pending and explain to patient what is needed. OUMC – Check Meditech for status.

**Why don't I qualify for Charity?**

Charity is provided to patients with certain income levels (see question # 1) and for only emergency medical care. You may qualify for government assistance or payment arrangements.

- OUMC – Must be a U.S. Citizen and a Resident of the State of Oklahoma.
- Any patient payment made on the account disqualifies the account for the Charity Program – (Exception: OUMC).
- Any patient or family member that does not cooperate with Government Programs may be denied charity.
- If denied by Search America (Third Party Vendor) – Inform patient that they were denied due to income guidelines (over-income).

**Can I apply for Charity to see if I qualify before I need services?**

No, Charity is considered only after your physician has ordered services or you have gone to the hospital for emergency care and already have an account number.

**Exception:** OUMC

- Patient must first go to OUMC Clinic to allow the staff to determine if the patient is in need of service.
- If approved by OUMC Clinic staff, the staff will supply the Financial Assistance Application at that time.
- Charity approval periods run 90 days from the time of charity approval for recurring services. The approval period is not applicable to homeless patients or patients with some form of insurance coverage (e.g. Medicare, Medicaid, etc.). After the initial approval, these patients will not be required to complete a new charity application or provide income documentation for 90 days from the time of approval. Pre-Approved charity patients must present a copy of the "Pre-Approval Letter" at the time of service for each account. If the letter is generated at OUMC, the letter is forwarded to the Dallas SSC Charity Department for final approval and processing of charity discount.

**I can't find my Charity Approval Letter and I need to go to the Hospital**

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The hospital will know when you go for services that you had charity approved for that period of time (Hospital staff can check Meditech for approval dates). You do not need another letter. We are not able to reprocess another approval letter until you go back to the hospital for additional services and have another account.

### ***I can't find my Charity Approval Letter and I need to go to the Doctor***

The physician charity approval process is separate from the Hospital's charity approval process. Please contact OU Physicians at (405) 271-1500. The hospital will let you know when you go for services that you had charity approved for that period of time.

### ***My pre-approved Charity Letter is about to expire – Can I extend my Pre-Approval?***

- Ask patient if they have an appointment
- When patient goes to OUMC Clinic, the OUMC Clinic staff will determine if services are required
- If services are required, the OUMC Clinic staff will provide a Financial Assistance Application at that time.

### ***What if Pending Medicaid and Pending Charity are Primary and Secondary and patient does not qualify for Medicaid?***

The Pending Medicaid and Pending Charity processes should not be concurrent processes. Determination of Pending Medicaid should be resolved prior to evaluating for potential Pending Charity. Action: Send e-mail to Charity Department Team Lead (Rodney Sherrard) and he will work with Government Programs to resolve account.

### ***I am receiving bills/collection phone calls for an account for which I was pre-approved.***

#### ***Action:***

- Ask patient to write the account number in question on the pre-approval letter
- Send (fax or mail) a copy of the pre-approval letter (with account number) to the Charity Department (877) 685-0593.

### ***Is there a Charity Denial Appeal Process?***

Patients who have been denied for a Charity discount have the option to appeal their denial by submitting a written request (within 30 days of Charity denial) with supporting documentation and/or missing documentation including the completed Financial Assistance Application. The review process should be completed within 14 days of receipt of all required documentation from the patient.

## **Coding**

### ***My insurance states the coding is wrong on my account, what do I do?***

Diagnosis and Procedure Codes are assigned by medical records coding professionals based on the physician documentation.

**Action:** Ask what code is being denied. If it is the diagnosis code, enter the request into the DET & place the request in the HIM REVIEW queue. If it is the procedure code (HCPCS/CPT), determine if the code is a HIM or Chargemaster assigned. If the code is an HIM code (refer to DET Grid – Available on Dalpas Online/PPRC/Support Services-Customer Service References, DAL.REF.AA.6004 DALLAS PATIENT ACCOUNT SERVICES REQUEST GRID 2008.08.01) enter the request into DET and place the request in the HIM REVIEW queue. If the code is a CDM assigned code (refer to DET Grid), enter the request into DET and place the request in the Chargemaster Review queue. If after HIM REVIEW or Chargemaster Review, a new code is assigned, a corrected claim will be sent to the insurance company. If the codes on the claim can be re-sequenced, forward an email request to the Billing Department.

## **Collections**

### ***Why was my account set to a Collection Agency?***

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After your insurance has paid, you will receive a statement requesting payment. If no payment or payment arrangements are made within 14 days, your account will be referred to our National Patient Account Services (NPAS) office in Louisville, KY or Bedford, TX. **This is not a collection agency and does not report to the credit bureau.** NPAS will provide you with payment options. Your insurance company determines the amount of your patient portion based on the policy you have with them. If you have any questions or concerns regarding this amount, please contact your insurance company.

If your account is still unresolved while at NPAS, it may be placed with a collection office such as NCO, FCA or West Asset Management. You will receive a final notice statement to notify you before placement with an agency. Making payments to an account without a payment arrangement will not keep your account from placing with the agency. If your account is with one of these offices, you must contact them directly for payment arrangements.

NPAS	1-800-223-9899
NPAS Complaint Line	1-800-944-1859
NCO	1-800-842-0640
FCA	1-800-880-2056
WEST ASSET MGMT / LLC	1-877-370-8738 EXT 245

**How do I get a statement showing I have a zero balance?**

We can request a statement on an account with a zero balance or we can print the payment or financial screen and mail or fax to you. **Action:** Request Artiva letter 3344 Zero Balance.

**Contracted Payors**

**How can I find out if my insurance is contracted with your hospital?**

Contact your insurance company and they will be able to tell you.

**What is a contractual adjustment?**

A discount your insurance receives with a specific hospital for a specific service according to a mutual contract.

**Discharge Date Requests**

**Insurance companies calling to request discharge dates**

If any of the following insurance companies call to request discharge date, refer them to their companies representatives below that receive a report daily of their members discharges and inhouse patients. If the insurance company is not listed below, explain to the insurance company that they can obtain the discharge date from the IVR System or we can set them up to receive a report daily. **Action:** Forward the name, phone number or email address of the Insurance UR Manager to Felicia Giddins to set up this process.

Aetna – Dawn (210) 575-2019

Amerigroup – Joan Cooper (866) 249-1292

BCBS Texas – Beverly Smith (972) 996-8545 or Linda Douglas (972)996-8417

CIGNA – Suzanne Kennedy (800)237-0377 ext 74143; Nan Hannush (800)237-0377 ext 73292

United Healthcare – Diana Vollmer (866)203-9168 x33989

UHC Ovations – Formerian Wiles (888)286-4909

Pacificare/Secure Horizons- Zachariah Higgins

**Dispute Charges**

**There are charges for items on my bill that I did not receive, how do I get these removed?**

You will need to complete the audit request forms and mail them to 10030 N MacArthur Blvd or fax it to 800-561-1743. Please be specific regarding the disputed charges. The account will be audited upon receipt of these charges and you will be advised of the outcome. This authorization allows us to have the Nurse Auditor pull your medical record to verify if the services or supplies were documented as being received. After the audit is complete you will be contact by mail with the results. If there are any charge corrections, a rebill will be sent to your insurance company. Crediting the charges may not affect your portion of the bill if your insurance company is contracted with us to pay a specific case rate depending on your time of service. **Action:** Request Letter from Artiva # 3363 Audit Request

When the Audit Authorization Form is returned, enter the request into DET and put in Patient Request Audit queue.

**Dispute Quality of Care**

**How do I dispute charges due to a quality of care complaint?**

Please contact, fax or mail a letter regarding the quality of care directly to the facility to the attention of the designee.

Hospital	Direct Line	Responsible Party	Fax #
Arlington	<b>817-472-4838</b>	<b>Juan Luna</b>	<b>817-472-4951</b>
Del Sol	915.595.9095	Diana Molinar	915.599.4033
Denton	940.384.3290	Mary Chambers	940.384.4736
Edmond	405.844.5718	Barbara George	405.359.5500
Green Oaks	972.770.0853	Marty Baudoin	972-701-3606
Las Colinas	972.969.2515	Vickie Clark	972.969.2396
Las Palmas	915.521.1270	Angie Frausto	915.599.4144
Lewisville	972.420.1803	Cindy Lang	972.353.6096
McKinney	972.547.8141	Carol Clark	469.713.8673
Medical City	972.566.2400	Theresa Neal	972-566-6489
North Hills	817.255.1176	Danny Stafford	866-743-1861
OUMC	405.271.6847	Joan Crall	405.271.1773
Plano	972.519.1163	Billie O'Brien	972.519.1480
Plaza	817.347.1430	Carol Vlasich Cindy Hatfield	817.347.1635 817.425.2737
Wesley	316.962.7843	Erin Janke	316.962.7385

**Dispute Private Room Difference**

**I should not be charged for the private room charges on my account. What do I do?**

Ask if the patient was in a private room because their physician ordered it or if they did not have a choice due to room availability or all rooms being private on this floor or at this hospital. **Action:** Apologize to the patient for the error. If the private room was ordered due to medical necessity, forward a DET Request to the facility in Facility NA/RI queue

to review the medical record for doctors order for the private room. If the private room was not ordered and the patient did not request, forward to your Team Lead to adjust the balance to correct patient portion.

## **Pharmacy Charges**

### **My pharmacy charges do not appear correct?**

The quantity reported is **not** the number of doses the patient received. The number reflects the units of medicine that are contained in a particular dose of medicine. We report the drug in units this way in order for the insurance company to pay us correctly for the drug.

For example, one dose of DRUG A injection for an adult may contain 50 mg. of a drug in one syringe.  
DRUG A 50 mg qty 1 @ \$XXX

The way the hospital is reimbursed for the drug per each 10 mg of drug given. So in order to be paid correctly we will report a quantity 5 (10 mg x 5 = 50mg) rather than quantity one of 50 mg.

DRUG A 50 mg QTY 5 @ \$XXX

The charge does not change and the dose hasn't changed only the way we report the amount of drug given is changed to reflect the actual billing units of the drug. (50 mg is the same as 10 mg x5)

## **Recovery Room Charges**

### **Why was I charged for a recovery room when I went straight to my room after childbirth?**

The actual recovery room charge is for the service of recovery after childbirth. Although you were not changed to a separate room for this, the service was still provided and the charges are valid.

### **I have been a victim of identity theft and am being billed for a service I did not receive?**

If you have been billed for services you did not receive and are a victim of identity theft, we can close the account with a copy of the police report and the Identity Theft Affidavit Form. You may mail these documents to HCA Patient Account Services at 10030 N MacArthur Blvd, Irving, TX 75063.

**Action:** Refer to DAL.PP.SS.1038 Procedure to Process Identity Theft Accounts

### **The charges are too high. I have had this service elsewhere for less?**

Charges vary at different hospitals and are based on what is considered reasonable and customary for the area. Emphasize and offer them payment arrangements.

## **Emergency room services**

### **Why am I being billed when I left prior to seeing the physician?**

Most facilities will charge for a medical screening ER Level 1. This is referred to as a "triage charge". If you disagree with the charges on your account, you may complete the audit request forms and mail these to 10030 N MacArthur Blvd, Irving, TX 75063 or fax it 800-561-1743. Most insurance companies will deny your claim and you will be responsible for the bill. (This shouldn't happen anymore –right?)

### **Why am I being billed for a pregnancy test?**

In an emergency situation, a pregnancy test may be ordered for any woman of childbearing age.

### **What are the other bills I am receiving for this service?**

You will receive bills from any providers, such as your ER physician, pathologist and radiologist For questions regarding these bills, please contact the provider's office directly.

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How is the ER Level determined?

The level is determined based on the severity of their illness and treatment needed.

Examples of Level 1 include:

<b>Level 1</b>
Initial Assessment No medication or treatment <b>Prescription refill only, asymptomatic</b> <b>Note for Work/School</b> Wound Recheck <b>Booster or Immunization, no acute injury</b> Dressing changes (uncomplicated) Suture Removal (uncomplicated)

Examples of Level 2 include:

<b>Level 2</b>
<i>Could include interventions from previous level plus any of:</i>
<b>Lab Tests (including those performed by ED staff)</b>
Fluorescein stain
<b>Visual Acuity (Snellen) Test</b>
<b>Immunization, with acute injury</b>
Apply ace/sling
<b>Prep/Assist Simple Procedures</b>
Obtain Clean Catch Urine
<b>Administration of Medications (e.g., PO, topical, rectal, drops, inhalant)</b>
<b>Post E.D. Care:</b>
OTC Medications or Treatments
Simple Dressing Changes

Examples of Level 3

<b>Level 3</b>
<i>Could include interventions from previous levels plus any of:</i>
<b>Receipt of EMS/Ambulance patient</b>
<b>Heparin/saline lock</b>
Nebulizer treatment (1)
<b>X-rays</b>
<b>Foley Cath/ I&amp;O Cath</b>
<b>C-spine precautions</b>
<b>Emesis/ Incontinence Care</b>
<b>Mental Health-anxious simple tx</b>
<b>Administration of Medications by Injection</b>
<b>DOA</b>
<b>Routine psych medical clearance</b>
<b>Limited Social Worker Intervention</b>
<b>Post E.D. Care:</b>
Prescriptions for Medications
Head Injury Precautions
Bending, Lifting, Weight Bearing Limitations

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Examples of Level 4

Level 4
<i>Could include interventions from previous levels plus any of:</i> Special imaging studies: MRI, CT, VQ Scan, U/S
<b>Cardiac Monitoring</b>
Nebulizer treatments (2)
<b>Port-a-cath venous access</b>
<b>Administration and Monitoring of Infusions</b>
NG/PEG tube placement/replacement
<b>Multiple Reassessments</b>
<b>Assist MD with diagnostic/ therapeutic procedure/ intervention, e.g. interventions requiring multiple resources and/or staff</b>
Psychotic patient; not suicidal
Pelvic Exam
<b>Sexual Assault Exam w/o specimen collection</b>

Examples of Level 5

Level 5
<i>Could include interventions from previous levels plus any of:</i> Monitoring vital signs of patient during in-hospital transport & testing Administration of Blood Transfusion/ Blood Products
<b>Oxygen via face mask or NRB</b>
Multiple Nebulizer treatments (3 or more); (if nebulizer is continuous, each 20 minute period is considered 1 treatment)
Moderate Sedation
Central line insertion
Lumbar Puncture
Paracentesis
Thoracentesis
Gastric Lavage
<b>Cooling/Heating Blanket</b>
<b>Extended Social Worker intervention</b>
Sexual Assault Exam w/ specimen collection by ED staff
<b>Coordination Hospital Admission (Inpatient or Observation)</b>
<b>Transfer or change in living situation or site</b>
Physical/Chemical Restraint
Suicide Watch
Crit Care < 30 min

What is a Trauma Activation Fee?

Our trauma hospitals charge this fee in the event a trauma patient is brought to the ER and the Trauma Team has to be initiated. Effective January 1, 2008, CMS assigned a revenue code for trauma activation fee (068X) for hospital billing. In order to bill this however, there must be a pre-hospital notification and the hospital must meet the either local, State or American College of Surgeons field triage criteria. Additionally, patients who are “drive-by” or arrive without notification cannot be charged for this activation fee. Payment may be made for interhospital transfers, provided the trauma center receives information about the trauma before the patient arrives. **No trauma activation fee is payable for patients who arrive without a pre-hospital notification.** If the patient was admitted to the hospital from the ER room, the trauma activation fee goes into the hospital charges submitted and is reimbursed depending on whether the patient is categorized as a diagnosis-related group outlier. If the patient’s insurance denies this charge, advise them to appeal based on the fact that it is a CMS approved charge.

## **Estimates**

You may be given an estimate of your total charges and estimated patient portion. This is not a final bill or final patient portion. Please be prepared for possible differences in the estimate and actual bill. Patients may use the Pricing Transparency Tool that is available on all hospitals' home page of their website by clicking on the link that looks like this.



The websites are:

IBIP Bill Payment & Inquiry Website Address
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[WWW.MEDICALCENTERARLINGTON.COM/BillingInq.ASP](http://WWW.MEDICALCENTERARLINGTON.COM/BillingInq.ASP)

[WWW.DELSOLMEDICALCENTER.COM/BillingInq.ASP](http://WWW.DELSOLMEDICALCENTER.COM/BillingInq.ASP)

[WWW.DENTONREGIONAL.COM/BillingInq.ASP](http://WWW.DENTONREGIONAL.COM/BillingInq.ASP)

[WWW.EDMONDHOSPITAL.COM/BillingInq.ASP](http://WWW.EDMONDHOSPITAL.COM/BillingInq.ASP)

[WWW.GREENOAKSNETWORK.COM/BillingInq.ASP](http://WWW.GREENOAKSNETWORK.COM/BillingInq.ASP)

[WWW.LASCOLINASMEDICAL.COM/BillingInq.ASP](http://WWW.LASCOLINASMEDICAL.COM/BillingInq.ASP)

[WWW.LASPALMASHEALTH.COM/BillingInq.ASP](http://WWW.LASPALMASHEALTH.COM/BillingInq.ASP)

[WWW.LEWISVILLEMEDICAL.COM/BillingInq.ASP](http://WWW.LEWISVILLEMEDICAL.COM/BillingInq.ASP)

[WWW.MEDICALCITYHOSPITAL.COM/BillingInq.ASP](http://WWW.MEDICALCITYHOSPITAL.COM/BillingInq.ASP)

[WWW.MEDICALCENTEROFMCKINNEY.COM/BillingInq.ASP](http://WWW.MEDICALCENTEROFMCKINNEY.COM/BillingInq.ASP)

[WWW.NORTHHILLSHOSPITAL.COM/BillingInq.ASP](http://WWW.NORTHHILLSHOSPITAL.COM/BillingInq.ASP)

[WWW.MEDICALCENTEROFPLANO.COM/BillingInq.ASP](http://WWW.MEDICALCENTEROFPLANO.COM/BillingInq.ASP)

[WWW.PLAZAMEDICALCENTER.COM/BillingInq.ASP](http://WWW.PLAZAMEDICALCENTER.COM/BillingInq.ASP)

[WWW.WESLEYMC.COM/BillingInq.ASP](http://WWW.WESLEYMC.COM/BillingInq.ASP)

[WWW.OUMEDICINE.COM/BILL](http://WWW.OUMEDICINE.COM/BILL)

[WWW.OUMEDICINE.COM/BILL](http://WWW.OUMEDICINE.COM/BILL)

## **Estate of**

### **What do I need to do if the patient has deceased?**

Whoever the caller is, be sympathetic and apologize for their loss. If the patient expired at the facility (the discharge status is 20), there will be a notation on the first screen. If not, request that they send a copy of the death certificate to

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HCA Patient Account Services at 10030 N MacArthur Blvd, Irving, TX 75063. **Action:** Ask if there is a surviving spouse. If there is change the RP to the surviving spouse. If there is not a surviving spouse change the RP to "Estate of" and the deceased patient's name. Change the Action Code to Bad Debt/Estate.

### **HIPAA**

#### **What is HIPAA/ Health Insurance Portability and Accountability Act?**

Laws governing how health information about you may be used and disclosed and how you can get access to this information. All patients are provided the Hospital's Notice of Privacy Practices upon registration or anytime requested. We must verify the identity of any person (including healthcare professionals) or entity from outside our organization when they are requesting protected health information (PHI) either in person, verbally or via written request. You will need the account number, last 4 digits of patient's social security number and the patient date of birth.

Do not release any diagnosis information or medical records to any caller. If you are made aware of a possible privacy violation, email the facts to DRSC Privacy email box.

### **Insurance**

#### **What is needed by me to follow up with my insurance on my claim status?**

You will need the name of the patient, the date/s of service and the account total charges. You will also need verification information such as the identification number and the patient's date of birth.

#### **If you do not have my correct insurance information, how do I provide that?**

You may mail your information to 10030 N MacArthur Blvd, Irving, TX 75063, email [HCA.CustomerService@hcahealthcare.com](mailto:HCA.CustomerService@hcahealthcare.com), fax your insurance card to 1-800-561-1743 or call Customer Service. We will need the name of the insurance provider, the product (HMO, PPO, Indemnity, POS, etc), name of the insured, policy number, group number, mailing address for claims, telephone number. It is helpful to forward a copy of your insurance card. If the account has not been written off to bad debt, we will bill insurance provided; however, if the correct insurance was not provided at the time of service and the claim is denied for late filing, you will be responsible for the charges. The exception is with Medicaid. If Medicaid information was not given at the time of service we cannot accept the information for billing after 90 days in Texas and 1 year in Oklahoma and Kansas.

### **IVR (Interactive Voice Response)**

#### **What services are available to me on the IVR system?**

You may get your account balance, information regarding patient or insurance payments posted to the account, request a copy of your itemized bill, and any needed mailing address. IVR can be utilized 24 hours a day, 365 days a year. A customer service representative is available Monday through Friday 8:00 am to 5:30 pm.

#### **Why am I being billed for late charges?**

These are charges that were entered after your account initially billed. **Action:** Verify that these late charges were rebilled to the insurance company.

### **Medicare**

#### **When is Medicare not primary?**

1. If you are 65 or older and currently working with coverage under an employer with a group health plan.
2. If you are 65 or older and are covered by a working spouse's employer group health plan.
3. If you are under 65, disabled, and covered by a large group health plan due to your own or family member's current employment status.

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4. With kidney failure, Medicare is secondary during the Coordination of Benefits period if you have coverage under your or other family member's employer group health plan. The COB period is 30 months.
5. If you receive services covered under Worker's Compensation, Federal Black Lung, automobile, no-fault or liability insurance plans.
6. If you receive services covered under the Veteran Administration.

**Medicare has wrong information on file, what do I need to do?**

You must go to the nearest Social Security Office or call 800-772-1213 to find the nearest office to them, to have their records corrected. You may also call Medicare at Medicare at 800-999-1118.

**What are Medicare non-covered charges billed to me?**

1. Self administered medications or Outpatient Prescription Drugs are not covered by Medicare. As of November 17, 2004 these charges are included on your claim to Medicare. Medicare will deny and the charges will be forwarded to any secondary payor for consideration. Prior to November 17, 2004, we were unable to bill these to Medicare without patient request. If you have charges prior to this date that you would like a secondary payor to consider, please contact Customer Service and request they be billed.
2. Certain Laboratory, radiology and cardiovascular test for which you have signed an Advanced Beneficiary Notice.

**Medicare has paid, what is this balance?**

Medicare Part A has an inpatient deductible per spell of illness and outpatient coinsurance. There is a copay for Inpatient Part A Skilled Nursing Facility charges day 61 through 150.

Medicare Part B has an annual deductible and various copay amounts.

**What is Medicare Part A and Part B?**

Part A is hospital (inpatient) insurance. Part B is medical (outpatient) insurance.

**Who is Mutual of Omaha or WPS (Wisconsin Physician Services)?**

Medicare contracts with 2 large insurance companies to process their Medicare claims. Not all hospitals have Blue Cross/Blue Shield, which is what most individuals are used to seeing. Our contract is with Mutual of Omaha, but is still Medicare.

**Medical Records**

**How may I get a copy of my medical records?**

You will need to contact the Medical Record Department at the hospital.

Action: Provide the caller with the facility direct number and offer to transfer them.

**How may my insurance get a copy of my medical records?**

We must receive a written request on letterhead stationery from your insurance company. The insurance company may mail or fax the request to us. If the insurance is not one that was listed at the time of service, we must have a HIPAA-compliant authorization.

**Minor Children**

**Who is responsible for my child's hospital bill?**

Both parents are responsible for the minor child's bill. The parent signing the Consent for Treatment will be listed as the responsible party if possible. The responsible party will not be changed. If a court order determines one parent should pay medical expenses, the parents should make this arrangement between themselves. We can add a second parent as a responsible party if requested.

**When is a minor considered emancipated?**

A child that no longer requires parental guidance or financial support, fathered or gave birth to a child or has reached the age of majority is considered emancipated and responsible for their charges.

## **Newborn Accounts**

### **Why are my baby's charges not billed with mine?**

All newborns will have their own account number. All babies will also receive a bill for their own room charges, although they may have stayed much of the time in mother's room.

### **When will I receive my baby's birth certificate?**

Birth Certificates will be filed with the state no more than 5 days after birth. Any changes done after the filing are the responsibility of the parents and must be done through the County Clerks Office or the State Department of Vital Statistics. A copy of the Birth Certificate may be obtained by contacting the County Clerk's Office or the State Department of Vital Statistics.

## **Online Services**

### **Can I view or pay my account online?**

Yes, you will need your account number, patient's date of birth and the patient's social security number.

### **Can I contact Customer Service via email?**

Yes, email [HCA.CustomerService@hcahealthcare.com](mailto:HCA.CustomerService@hcahealthcare.com)

## **Out of Network**

**My insurance company states I should get an in network discount and you are not processing as such?** Please mail a copy of your EOB to 10030 N MacArthur Blvd, Irving, TX 76053 with this discount shown. In order for your insurance to take a network discount, this logo must be on your insurance card. Please include a copy of the card with logo if possible.

### **My insurance is processing the physician bill without a discount as not in network but I went to your in network hospital and you selected the physician?**

Appeal for additional payment with your insurance.

## **Patient responsibilities**

### **Why am I being billed after you have been paid by the insurance?**

If you are insured, you will have one or more of the following:

**Coinsurance:** A form of cost sharing. After your deductible has been met, the plan will begin paying a percentage of your bills. The remaining amount, known as coinsurance, is the portion due by the patient.

**Deductible:** Provisions that require the member to accumulate a specific amount of medical bills before benefits are provided. For example, if a member's policy contains a \$500 deductible, the member must accumulate and pay \$500 out of pocket before the insurance will pay.

**Copay:** A set fee the member pays to providers at the time services are provided. Co-pays are applied to the emergency room visits, hospital admissions, office visits, etc. The cost is usually minimal.

## **Patient Type**

### **Why am I considered an outpatient when I stayed in a hospital room?**

You may be in the hospital for observation. Observation services are usually short term; however, there is no hourly limit on the extent to which they may be used. This is not an admission to the hospital as an inpatient. The determination for observations services or to be admitted as an inpatient is made by the attending physician and based on medical necessity. If you believe you have been incorrectly coded in this regard, please complete the Audit Request

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Forms (link) and forward to HCA Patient Account Services, 10030 N MacArthur Blvd, Irving, TX 75603 or fax to 800-561-1743. We will review your account and advise you of the outcome.

**Payment arrangements**

**Can I make payment arrangements?**

Yes, you must contact Customer Service and request this arrangement.

There is a minimum payment due according to your account balance. Payment Plans must be at least \$25.00 monthly and recommended plans are as follows:

Payment Resolution	
Tier B	
Moderately Aggressive	
Balance Due	Minimum Monthly Payment
\$10 - \$150	\$25
\$151 - \$250	Divide by 6
\$251 - \$350	\$50
\$351 - \$500	Divide by 7
\$501 - \$900	\$75
\$901 - \$1,000	Divide by 12
\$1,001 - \$2,400	\$100
\$2,401 & above	Divide by 24

**Payment Options**

**What are my payment options?**

You can pay your account in person by cash, check or credit card, over the telephone with a credit card or check by phone and online with a credit card.

**Physician discounts**

**Are physician discounts available?**

Some of our facilities do offer a discount of up to 25% of the expected reimbursement for non-employed physicians and their immediate family. To inquire about this, please contact Customer Service. Action: Forward email to Customer Service Team Lead.

**Physician Office Calls**

**I need billing information.**

Please fax all request for billing information to 800-561-1743.

**Pre-Admission Testing**

**My insurance states that the pre-admit test should be combined with my surgery.**

Send an Audit Authorization Form and once received submit a DET request to the Facility Nurse Auditor to ask if the accounts should be combined. The nurse Auditor will need to move the charges if they are to be billed together.

**Pre-Authorization or Pre-Certification**

**Insurance has denied for pre-authorization, why am I being held responsible for the bill?**

If you did not present your current insurance card at the time of service, the hospital would not have the opportunity to contact them for authorization. In some cases, insurance will not pay for hospital costs if patients do not pre-certify. You may need prior authorization or pre-certification for medical treatment. Please discuss this in advance with your physician and your insurance company. Filing of claims with your insurance company does not guarantee coverage.

## **Refund requests**

### **Will I receive my insurance company's overpayment?**

Insurance company overpayments are refunded to the insurance.

### **What will happen to my credit if I have an open account?**

Your credit will be transferred to any accounts with open balances.

### **Who is the refund made payable to?**

The refund is made payable to the payer on the account.

### **How long will it take for me to get my refund check?**

10-14 business days

## **Statements**

When an account balance is released to the patient, a statement will be automatically generated to the Responsible Party.

### **Statements Generated in Error:**

- I-plan Changes
- Recoups
- Non-Covered Charges placed to the patient in error
- When the account balance is not properly prorated to the insurance

## **Uninsured Discount**

All Self Pay patient accounts, excluding elective cosmetic procedures, facility designated self pay flat rate procedures and scheduled/discounted procedures for International patients will be given an Uninsured Discount. Payment arrangements and prompt pay settlements are not excluded with this discount.

## **W-9 or Tax Identification Number**

You may obtain a copy of this form by contacting Customer Service. These forms are located on the Dallas Online Website under Facility/Important Documents/W9....