Credit Policy Policy F-1100

Department(s)	*Branch Operations, Funding, Supply Chain*
Effective Date	***September 1st, 2015***
Version Number	***4***
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Scope

All National Seating & Mobility policies and procedures apply to all owners, directors, officers, and employees of NSM and all related entities equally unless otherwise indicated.

Purpose/Policy Introduction

National Seating & Mobility is in the business of providing quality care, products, and services to our clients. To enable us to continue to provide these services, we must be fairly reimbursed for the quality services that we provide.

The Credit Policy is in place to minimize the risk of non-payment and to identify the amount of reimbursement prior to purchasing. Failure to follow the minimum requirements outlined below increases the risks of delayed payment, non-payment, and/or insufficient reimbursement as well as non-compliant actions regardless of intent.

Policy

It is NSM policy that, prior to purchasing equipment, we take the necessary steps to identify the amount of expected reimbursement and to minimize the risk of non-payment. This policy outlines the documents and/or actions that are required prior to the issuance of purchase orders and prior to delivery of equipment. Depending on the payer(s), NSM has different requirements. These are the minimum requirements.

Procedure

All requirements for each payer the client is eligible for must be met prior to the issuance of purchase orders and/or delivery of equipment. This includes appropriate approvals, valid denials, valid waivers, and all required clinical documentation required by each individual payer. It is also critical that we are confirming the client's ability to pay any estimated client responsibility due and are collecting these amounts prior to purchase and/or delivery, in all scenarios in which the payer allows. Adhering to the minimum requirements outlined will insure that NSM identifies where all reimbursement and funding will come from prior to the purchase and/or delivery of equipment.

Client Responsibility

For **all** orders and payers, the following requirements regarding client responsibility should be followed in addition to what is listed for each individual payer, unless otherwise stated below or in the payer's UPD*:

- Review, validate, discuss, **and collect** client responsibility for co-payments, deductibles, non-covered items, and/or upgrade items prior to purchase when allowed by payer.
    - For rental equipment, collect all estimated coinsurance due for the full rental period.
- Review, validate, discuss, **and collect** or resolve any remaining past due client balance(s) from previous orders as shown in **Patient Invoiced** field.
    - Once collected, if previous balance was past due, the current order is also not eligible for a Credit Exception to purchase without collection of the current order client responsibility balance.
    - If unable to collect a previous outstanding balance due, discuss with leadership prior to proceeding with current order. The previous balance must be collected or resolved, the current work order client balance must be collected, and a Credit Exception approval is required to proceed.

Requirements by Payer

Medicare

- Medicare Part B eligibility verified including verification of Hospice.
- Place of Residence verified.
- History of Previous Equipment verified.
- All required Submission and Pre-Delivery documents per the UPD received.
    - All required Delivery documents secured at time of *delivery*.
- Advance Beneficiary Notification (ABN) form (when required by payer and/or NSM policy).
- Approval received, when available, via ADMC or PAR.
- *Medicare guidelines require co-pay and/or deductible to be collected at the time of *delivery.* For rental equipment, collect the first month rental co-pay only. Remaining months will be billed directly to the client. Non-covered items follow the above standard procedure.

Medicaid

- Eligibility verified.
- Place of Residence verified.
- All required Submission and Pre-Delivery documents per the UPD received.
    - All required Delivery documents secured at time of delivery.
- Approval received, when available and as required by payer.
- Medicaid wavier or ABN form (when required by payer and/or NSM policy).

Commercial/Contracted Payers

- Eligibility verified.
- Place of Residence verified.
- All required Submission and Pre-Delivery documents per the UPD received.
    - All required Delivery documents secured at time of *delivery*.
- Written pre-authorization, pre-certification, pre-determination, or other decision is required when available.
    - If payer offers a written authorization on some, but not all lines, verbal verification that all remaining codes are covered must be obtained and documented on the **Verbal and Partial Authorization Log**.
- In scenarios in which the payer does **not** offer a pre-authorization, pre-certification or pre-determination for the base and/or any items on the order, verbal verification that all codes are covered must be obtained and documented on the **Verbal and Partial Authorization Log**. The following steps must be followed:
    - If the payer has published coverage criteria, validate all criteria has been met.
    - If the payer does not have published coverage criteria, discuss and have client complete the **Unconfirmed Insurance Coverage Notification** prior to proceeding.

Non-contracted Payers

- Eligibility verified.
- Verification that NSM can provide service and be paid in or out of network.
- Place of Residence verified.
- All required Submission and Pre-Delivery documents per the UPD received.
    - All required Delivery documents secured at time of *delivery.*
- Written pre-authorization, pre-certification, pre-determination, or other written payer decision is required when available.
    - If payer offers a written authorization on some, but not all lines, verbal verification that all remaining codes are covered must be obtained and documented on the **Verbal and Partial Authorization Log**.
- Secure an approved Letter of Agreement (LOA) or Single Case Agreement (SCA) to establish and allow reimbursement. Follow the steps documented in NSM's published LOA/SCA Process Job Aid to submit a PSP ticket.
- If payer does not offer a pre-authorization, pre-certification or pre-determination and SCA/LOA, NSM cannot proceed with the order and the client should be referred to their health plan to identify an in-network provider.

Self-Pay and Access Self-Pay Orders

- Verify that the client does not have any insurance that will cover the requested equipment.
- Collect any required waivers or ABNs as required by payer guidelines.
- Prior to purchase, at minimum, a 25% non-refundable deposit must be collected.
- Prior to delivery, the remaining balance must be collected.

Other Institution Orders/Non-client Orders

Other institution/non-client orders refer to entities (such as institutions, associations, school districts, etc.) that purchase equipment for their own use or for a specific client's use in lieu of a health insurance plan.

- If available, review past orders for the entity to ensure there are no outstanding balances, confirming the entity does not have a poor payment record with NSM.
- Full payment, written authorization, email confirmation, and/or purchase order for a specific dollar amount must be secured.
    - In scenarios in which written auth or payment in full is not available, prior to purchase, at minimum, at 50% deposit must be collected with the remainder due at the time of delivery.
- All required Submission and Pre-Delivery documents per the UPD received.
    - All required Delivery documents must be secured at time of delivery.

Denials

Patient-Responsibility (PR) denials are required in most cases to bill and collect payment from other payers or to collect payment from a client. When a denial is a requirement on an order, it must be deemed valid before proceeding and we must fully understand the denying payer's guidelines as well as the requirements for the payer funding the order.

Examples of **valid denials** include but not limited to the following:

- Denials for non-covered items or benefit denials.
- Denials that allow billing to other payers.

Examples of **invalid denials** include but not limited to the following:

- Denials for missing or incomplete documentation, including not ruling out lower-level equipment.
- Denials for COB or for not obtaining a decision from a primary payer.
- Denials for not following payer rules or coverage criteria.

Credit Policy Deviation

These policies are designed to ensure the financial success of NSM and to guarantee payment on our valuable work. We recognize that this is a business of both specific and general exceptions. To that end, there are certain circumstances that may require an exception to this policy. *(See Policy F-900 Credit Exception Policy)*

- A specific exception is for an individual order and is obtained via a Credit Exception to allow processing of an order outside of the parameters of NSM's Credit Policy. These are non- recurring case-by case situations. Credit Exceptions for purchasing may be approved by the process outlined in Policy F-900 Credit Exception Policy.

- A general exception is a specific exception that addresses unique payer processing requirements, including but not limited to discharge processes, state laws or other market dynamics that create a need for an approved standing deviation from Policy F-900 Credit Exception Policy. These are recurring situations approved by the Funding Vice President, Division Vice President, or Chief Revenue Cycle Officer and are traditionally housed on WNSM.

Credit Policy Violations

Deviations from NSM's credit policy that are not pre-addressed or pre-approved by a valid exception request (specific or general exception as defined above) will be investigated and adjudicated by NSM executive management.

Any individual deemed responsible for an unauthorized deviation from the credit policy will be counseled and/or provided additional training, as appropriate, based on the situation to prevent future occurrences of unacceptable deviation from policy as follows:

OMISSIVE VIOLATIONS: Certain deviations from credit policy may be of an omissive nature. These deviations could result from an inadvertent act, a misunderstanding, a misinterpretation, negligence, or other mistake made by the employee that was not willful or deliberate. Omissive violations will be reviewed on a case-by-case basis. The course of remedial action deemed appropriate will be based on a review of the specific offense, a review of the employee's past performance, past violations of the same or similar type, and other pertinent factors to ensure that the response matches the infraction. Typical actions taken in response to omissive violations may range from verbal counseling to termination of employment.

COMMISSIVE VIOLATIONS: Deliberate, knowing, pre-meditated or deliberate violations of credit policy are commissive in nature. These are very serious violations of credit policy for which NSM reserves the right to pursue all remedies, including termination and prosecution.

This policy is intended to cover our most common scenarios. Any scenario or exception that falls outside of these guidelines should be discussed with funding and operational leadership. When appropriate, specific exceptions or alterations can be accommodated to help address rare scenarios that aren't outlined in policy. Should you have any questions regarding a change to this policy, please contact your supervisor or funding leader.

References/Resources

- Policy F-900 Credit Exception Policy
- Refer to WNSM > Funding > Funding Resources > Funding Forms for all approved General Credit Exceptions
- Letter of Agreement (LOA) /Single Case Agreement (SCA) Process
- WNSM > Payer Relations > Payer Relations Ticketing System (PSP)
- **Notification of Unconfirmed Insurance Coverage** Letter:
  This letter is only used and collected when a prior authorization and/or pre-determination is **not** available for the base and/or entire order (do not use for individual accessories when remainder of order and/or base item is approved), **and** the payer does not have any published coverage guidelines for the equipment being provided.

Definitions

Term	Definition
UPD	Universal Payer Database – System used to house all known payer information and requirements
ABN	Advanced Beneficiary Notification - Form used to inform Medicare Beneficiaries of non-covered items
SCA	Single Case Agreement to provide services
LOA	Letter of Agreement to provide services
PSP	Payer Services Portal used to submit Tickets to Payer Relations
Funding Leader	Funding Supervisor, Funding Manager and/or Funding Director

Policy History

Creation/Revision/Review Date	Author/Reviewer	Approved by	Description
September 1st, 2015	Compliance/Funding/VPs	Compliance/Funding/VPs	Policy Creation
February 25th, 2016	Karen Shell	Funding/DVPs/Compliance	Removal of Consent/AOB form requirement, update of exception contact and Medicare documentation section
January 20th, 2022	Funding/DVPs/Compliance	Funding/DVPs/Compliance	Updated and added UPD guidelines to documentation section, added upgrade guidelines, added rental information, removal of dollar thresholds and FAQs.
August, 19th 2024	Funding	Revenue Cycle DVPs Compliance Payer Relations	Updated to standardized policy formatting. Added emphasis on client responsibility. Added references/resources. Removed NSAL, added Notification of Unconfirmed Insurance Coverage letter guidelines, and SCA/LOA requirements. Removed redundant language.