

Table of Contents

I. Purpose	2
A. Overview	2
B. Scope	3
II. Definitions	3
III. Classification and Access to Care	5
A. Overview	5
B. Types of Services	6
1. Emergent and Urgent Services	6
2. Non-Emergent, Non-Urgent Services	6
C. Acquisition and Verification of Patient Information	7
D. Patient Responsibility	7
G. Non-Discrimination Policy	8
IV. Patient Billing and Collections	8
A. Overview	8
B. Patient Billing	8
C. Patient Statements, Letters, and Calls	9
1. Collection Calls and Letters	9
2. Notification of Availability of Financial Assistance	9
3. Patients Protected from Collection Action	9
4. Final Collection Notice	10
5. Suspension of Billing	10
6. Emergent Bad Debt	10
7. Bad Address Returns	10
8. Small Balance Adjustment	10
9. Surcharge Notice	11
10. No Balance Billing	11
D. Special Situations – Billing	11
1. Patient Bankruptcy	11
2. Deceased Patients	11
3. Motor Vehicle Accidents (MVA) and Third-Party Liability (MA)	11
4. Motor Vehicle Accidents (MVA) and Third-Party Liability (NH)	12
5. Workers Compensation	12
6. HSN Secondary Coverage	12
7. Partial HSN Deductible	12
8. Victims of Violent Crimes	12
V. Financial Clearance	12
A. Overview	12
B. Preparation of Estimates	13
1. Good Faith Estimates	13
C. Insured Patients	14
1. Contracted Insurance Plans	14
2. Non-contracted Insurance Plans	15
D. Uninsured Patients (Self Pay)	15
E. Low Income Patients (Massachusetts Residents)	16
1. Definition and Eligibility	16

2. Service Limitations	16
3. HSN Medical Hardship	16
4. Low Income Patient Financial Responsibility	17
5. Pending Status Determinations	18
F. Special Situations for Financial Clearance – Registration and Patient Financial Responsibility	18
1. Workers Compensation	18
2. Motor Vehicle Accidents (MVA) and Third-Party Liability	18
3. Victims of Violent Crimes and Violence Against Women (MA)	19
4. Health Information Technology for Economic and Clinical Health Act of 2010 (HITECH)	19
5. HSN Confidential Applications	19
6. Undocumented Persons	19
7. Research Studies	19
8. Organ Donors	20
9. International Patients	20
G. Serious Reportable Events (SRE)	20
H. Bad Debt Placement	20
1. Credit Reporting	20
2. Litigation	20
3. Property Liens	21
4. Collection Agencies	21
VI. Payment Arrangements	21
A. Overview	21
1. Forms of Payment	21
2. Currency	22
B. Payment Plans	22
1. Payment Plans for HSN Partial Deductibles and Medical Hardship	Error! Bookmark not defined.
VII. Credit Balances and Refunds	22
Appendix A: Affiliated Mass General Brigham Entities	23
Appendix B: Financial Assistance Application	24
Appendix C: Reporting, Audit, and Compliance with Regulations	25

I. Purpose

A. Overview

Mass General Brigham (MGB) entities are tax-exempt entities, whose underlying mission is to provide services to all in need of medical care. MGB strives to ensure patients requiring urgent, emergent, and medically necessary services shall not be denied those services based on their inability to pay, and that financial capacity does not prevent these individuals from seeking or receiving care. However, for Mass General Brigham entities to continue to provide high quality services and support community needs, each entity has a responsibility to seek prompt payment for services where collection is allowed and not in conflict with Commonwealth of Massachusetts (MA) and New Hampshire (NH) regulations or Federal regulations including Emergency Medical Treatment and Labor Act (EMTALA).

This document outlines the process of the collection of medical costs from individual patient accounts by MGB – and potential external collection agencies retained by MGB – and establish consistent practices for collections ([Section IV](#)), aiding individuals who are unable to pay (via payment plans or financial assistance) ([Section VI](#) and [Section IV\(C\)\(2\)](#)), or potential legal action ([Section V\(H\)](#)).

B. Scope

This policy applies to Mass General Brigham entities outlined in [Appendix A](#).

Note: Physicians associated with these entities, but who bill “privately” are encouraged, but not required, to follow this policy. Details may be found on the Mass General Brigham Provider Affiliate List.

II. Definitions

Behavioral Health Services: Medically necessary services that focus on the patient’s psychological and mental health and may be provided in several care delivery settings.

Elective Services: Medically necessary services that do not meet the definition of Emergent or Urgent Services. The patient typically, but not exclusively, schedules these services in advance.

Emergent Services: Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e) (1) (B) of the Social Security Act, 42 U.S.C. § 1295dd(e)(1)(B). A medical screening examination and treatment for emergency medical conditions or any other such service rendered to the extent required pursuant to the Emergency Medical Treatment and Labor Act (**EMTALA**) (42 USC 1395(dd)) qualifies as Emergency Care.

Emergent services also include:

- Services determined to be an emergency by a licensed medical professional
- Inpatient medical care which is associated with the outpatient emergency care; and,
- Inpatient transfers from another acute care hospital to a Mass General Brigham hospital for the provision of inpatient care that is not otherwise available.

Emergency Bad Debt: A classification of patient accounts submitted to Massachusetts Health Safety Net (HSN) in accordance with criteria described 101 CMR 613.06(2) where uncompensated care is accounted for through HSN.

Federal Income Poverty Guide (FPG): A measure of income issued each year by the Department of Health and Human Services (HHS). These guidelines are used to determine eligibility for certain programs and benefits (such as Medicaid).

Financial Assistance: A provision of healthcare services provided for free or discounted to eligible patients, with documented and verified financial need, who meet the criteria established within this policy.

Financial Assistance Discounts: Adjustments to patients' balances that are made based on the patient's financial status according to the Financial Assistance Policy. All discounts for Financial Assistance must be in accordance with state and federal regulations including IRS 501 (r).

Financial Counselor: Representatives responsible for assessing a patient's liability, to identify, assist or refer with public funding options (Medicare, Medicaid, etc.), determining if patient is eligible for financial assistance, and establishing payment plans.

Financial Counseling: Services provided to patients without sufficient insurance coverage, unable to pay their estimated/actual liability prior to the treatment, or who have large past due balances.

Low Income Patient: an individual who is a Resident of the Commonwealth of Massachusetts and document that the Modified Adjusted Gross Income (MAGI) of his or her MassHealth Household is equal to or less than 300% of the FPL. The state of New Hampshire poverty guidelines is 250% of the FPL.

Medicare Bad Debt: The expense that CMS/Medicare allows hospitals to claim for most unpaid Medicare co-insurance and deductibles, provided the balance is completely processed per the established self-pay billing cycle or a determination is made that the patient is indigent for the purposes of the balance. The determination of indigence must be based on the patient's income level and a review of their available assets which typically excludes their vehicles and primary residence and a minimum bank/checking account.

Medically Necessary Services: Services that are reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity. Medically Necessary Services include inpatient and outpatient services as authorized under Title XIX of the Social Security Act.

Other Services: Services where medical necessity has not been demonstrated to the reviewing clinician or where the patient's qualifications for the service may not meet the general insurance plan definitions for meeting key medical necessity criteria for the service. Other Services also include services that many insurance plans ~~do~~ may not consider to be Medically Necessary, including, but not limited to: Cosmetic Surgery, In-Vitro Fertilization (IVF) or other Advanced Reproductive Therapy (ART), Gastric Bypass Services absent of a payer's determination of medical necessity, and Patient Convenience Items such as charges related to overnight services above and beyond those needed for medical care or patient overnight services (inpatient or partial hospitalization) where there isn't a clearly demonstrated medical necessity.

Patient Billing Solutions (PBS): The department at Mass General Brigham responsible for all self-pay revenue cycle processes including Customer Service, Collections, Financial Assistance determinations (other than WDH which determinations are made at that entity) and processing, Bad Debt processing, patient credits/refunds and associated processes.

Patient Liability: The financial responsibility that is due to the facility/provider as a result for receiving health care services; the amount is determined according to a patient's insurance benefits for the specific scheduled service; including deductibles, co-payments, co-insurance, and non-covered services.

Post-Acute Care: Medically necessary services, including rehabilitation services, provided at a Hospital that is classified as post-acute.

Self-pay: Patient identified as having no insurance coverage or opting out of their insurance coverage for specific services/events.

Uninsured Patient: A patient that does not have any health insurance in effect for a specific date of service or where their coverage is not effective for a specific service due to network limitations, insurance benefit exhaust or other non-covered services.

Underinsured Patient: A patient with some insurance or other third-party source of payment, whose out-of-pocket expenses exceed his/her ability to pay.

Urgent Services: Medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health.

Inpatient: Inpatient level of care is when a patient is admitted to a hospital or other care setting for treatment that requires at least one overnight stay. Inpatients typically need more extensive care or monitoring which could include surgery or treatment for more serious conditions.

Outpatient: Outpatient level of care is when a patient receives medical treatment or care without being admitted to a hospital for an overnight stay, treatment that is done in the doctor's office or other medical clinic within a single day and returns home the same day.

Observation: Observation level of care is a hospital outpatient service that allows a doctor to determine if a patient needs inpatient care or can be discharged. Observation status is based on the level of care a patient needs, not the length of their hospital stay. A patient's status may change if their condition improves or worsens, or if they need more or less care.

Recovery Unit: A hospital unit for patients who have had a surgical procedure and requires extended recovery time or inpatient short stay.

* Patient classification status is not dependent on the patient location (floor/unit) but is representative of the level of care.

III. Classification and Access to Care

A. Overview

All patients presenting for unscheduled treatment will be evaluated according to the classifications included in this section. Urgent or Emergent hospital services shall not be denied or delayed based on the MGB's ability to identify a patient, their insurance coverage or ability to pay.

However, non-emergent or non-urgent health care services may be delayed or deferred based on the consultation with MGB's clinical staff in those cases when MGB is unable to determine a payment source for its services. The urgency of treatment associated with each patient's presenting clinical symptoms will be determined by a medical professional as established by local standards of practice, national and state clinical standards of care, and MGB medical staff policies and procedures. Further, all hospitals follow the Emergency Medical Treatment and Active Labor Act (EMTALA) requirements by conducting a medical screening examination to determine whether an emergency medical condition exists.

B. Types of Services

1. Emergent and Urgent Services

MGB will provide emergent and urgent services without regard to the patient's identification, insurance coverage or ability to pay. Registration and intake of emergent and urgent patients will be performed in accordance with the requirements of EMTALA. Patient demographic and insurance information should be collected as soon as possible. However, the collection of information should be deferred when collection of this information may delay medical screening or negatively impact the patient's clinical condition. When a patient is unable to provide insurance or demographic information at the time of service and the patient consents, every effort should be made to interview friends or relatives that may accompany or be otherwise identified by the patient. Where practical, insurance information provided by the patient should be confirmed with the payer via a payer website or an electronic data interchange (EDI) or Real-Time Eligibility (RTE) process.

2. Non-Emergent, Non-Urgent Services

Registration and intake of non-emergent/non-urgent patients should be performed prior to services being rendered. Returning or established patients will also have the demographic, financial and insurance information reviewed and updated as needed, including where applicable, verification of their insurance status via EDI/RTE or other available methods. Non-emergent, non-urgent services can generally be sub-classified as either:

- Elective Services
- Other Services
- Post-Acute Care
- Behavioral Health Services

MGB may decline to provide a patient with non-emergent, non-urgent services in those cases when MGB is not successful in determining that payment will be made for its services. Per [Section III\(F\)\(2\)](#) below, patients with Health Safety Net Full and Health Safety Net Partial will be presumptively eligible for Financial Assistance- patients will be able to seek care for eligible services (per [Section III\(C\)](#)) without a Financial Assistance Application. Services that are determined to be non-medically necessary may be deferred indefinitely until suitable payment arrangements can be made. These include but are not limited to:

- cosmetic surgery
- social, educational, and vocational services

C. Acquisition and Verification of Patient Information

- MGB will make diligent efforts to positively identify all patients and obtain, record, and verify complete demographic and financial information for every patient seeking care.
- The information to be obtained will include demographic information (such as patient name, address, telephone number, social security number if applicable, gender, date of birth and applicable patient identification), and health insurance information (including name and address, subscriber information, and benefit information such as co-payment, deductible, and co-insurance amounts) sufficient to secure payment for services.
- The requirement for MGB to obtain complete information will always be tempered by the patient's condition, with the patient's immediate health care needs taking priority.
- It is the patient's obligation to provide complete and timely insurance and demographic information and to know what services are covered by their insurance policy.

D. Patient Responsibility

It is the patient's obligation to:

- Provide complete and timely insurance and demographic information and inform MGB, (and the State if patient is on a State Program) of any changes in their insurance or demographic information including, but not limited to, changes in income or insurance status.
- Apply for and maintain coverage through any government sponsored program(s) for which they may qualify, including submission of all required documentation within the required timeframes. All patients should obtain and maintain insurance coverage if affordable coverage is available to them.
- Notify MGB of any potential Motor Vehicle Accident coverage, Third Party Liability coverage, or Workers Compensation coverage ([Section IV\(D\)](#) and [Section V\(F\)](#)).
 - For patients covered by a State Program, file a claim for compensation, if available, with respect to any accident, injury or loss and notify the State Program (e.g., Office of Medicaid and the Health Safety Net) within ten days of information related to any lawsuit or insurance claim that will cover the cost of services provided by MGB.
 - A patient is further required to assign the right to a third-party payment that will cover the costs of the services paid by the Massachusetts Office of Medicaid or the Health Safety Net.
 - The state of New Hampshire cannot bill to motor vehicle coverage. Patient has the option to bill to their medical insurance or be patient liable.
- Make reasonable efforts to understand the limits of their insurance coverage including network limitations, service coverage limitations and financial responsibilities due to limited coverage, co-payments, co-insurance, and deductibles.
- Follow insurance referral, pre-authorization, and other medical management policies, where applicable.

- Complete any other insurance requirements, including, but not limited to completion of coordination of benefits forms, updating membership information, updating physician information.
- Pay co-pays, deductibles, and co-insurance amounts in a timely manner.
- Provide timely updates of demographic, insurance and HSN eligibility, and annual deductible data.

G. Non-Discrimination Policy

MGB will not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, gender identity, sexual orientation, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions, or eligibility for the Health Safety Net.

IV. Patient Billing and Collections

A. Overview

Acute Care Hospitals and other MGB providers will make diligent efforts to collect all charges that are due from insurers according to established industry standards and will seek to apply payments and contractual adjustments on a timely basis to the patient's account. These efforts include billing all available insurance plans according to the payers' requirements and timely follow up of denied claims. Patients or other guarantors will be held responsible for all account balances that remain after application of all insurance payments, contractual adjustments, and agreed on discount/adjustments in accordance with any remittance advice received from the payer except where the balance may be submitted to the HSN or deemed exempt from collection actions per state regulation. Collection actions may include patient statements, patient letters, telephone contacts and certified final collection notices.

B. Patient Billing

MGB has a consistent process for submitting and collecting payment for services at Acute Care Hospitals and other MGB Providers (see [Appendix A](#) for full list). MGB will follow the following collection/billing procedure:

- An initial bill is sent to the patient or the party responsible for the patient's personal financial obligations (e.g., third party payor)
- MGB will send subsequent billings, telephone calls, collection letters, email notifications, or any other method of communication employed by MGB (see [Section IV\(C\)](#)) that constitutes a genuine effort to contact party responsible for unpaid bill.
- We will attempt to collect an outstanding balance for 120 days from date of initial bill.
- After 90 days, a final collection notice will be sent. Emergency Department accounts over \$1,000 will be sent via certified mail.
- We will retain documentation of these efforts in accordance with internal document retention policies.

C. Patient Statements, Letters, and Calls

Acute Care Hospitals and other MGB providers either directly or through its designated agents, will prepare or mail statements to patients on a regular basis to advise them of balances owed. To the degree possible, the patient will receive a summary of all charges, payments and adjustments included with the initial billing for each date of service. In general, patients should receive four (4) or more paperless/paper statements or letters over the course of a billing cycle that is expected to last at least 120 days provided that other actions do not occur which indicate that additional billing is inadvisable.

1. Collection Calls and Letters

Acute Care Hospitals and other MGB providers will make reasonable efforts to collect all outstanding balances due to MGB. The collection effort expended will vary depending on a number of factors including, but not limited to, the balance of the accounts and the patient's previous collection history. Additional collection efforts may include patient calls, emails, and letters to supplement the routine patient statement process as described in [Section IV\(B\)](#). To the degree possible, these calls and letters will include reminders regarding the availability of financial assistance.

2. Notification of Availability of Financial Assistance

Patient statements will include any notices required by regulations to inform patients of the availability and means to access financial assistance. The language and content of these notices will conform to current Executive Office of Health and Human Services (EOHHS) and IRS 501(r) regulations. Notices regarding the availability of financial assistance will also be included in all other written and verbal patient communications to the degree feasible. For more information, please see the [Financial Assistance for Uninsured](#).

3. Patients Protected from Collection Action

Acute Care Hospitals and other MGB providers will take reasonable steps to ensure that no collection actions, including telephone calls, statements or letters, are initiated for those patient balances that may be exempt from collection action by regulation, including patients determined to be a Low Income Patient by the Office of Medicaid (except for Dental-Only Low Income Patients), or enrolled in MassHealth/Medicaid, Children's Medical Security Plan (CMSP) with a MAGI family income equal to or less than 300% of the FPG, NH Medicaid with a MAGI family income equal to or less than 250% of the FPG, Emergency Aid to the Elderly, Disabled, and Children (EAEDC), and Health Safety Net (Full or Partial).

- If it is determined that a patient was enrolled in one of those categories, then all collection actions (except applicable co-payments, deductible, Medicaid spend-down, and HSN deductibles) with the patient will be closed for services that occurred during the patient's period of eligibility.
- Collection actions will also cease for as long as the patient is determined to be Low Income if the balance is from a period when the patient was not enrolled in a qualifying program.
- Acute Care Hospitals and other MGB providers may continue to send letters requesting information or action by the patient to resolve coverage and/or eligibility issues with a primary payer, Workers Compensation Program or to obtain any Third-Party Liability or MVA carrier information.

4. Final Collection Notice

Acute Care Hospitals and other MGB providers will make reasonable efforts to send each patient a final collection notice prior to the account being written off as Bad Debt. In most cases, the final collection notice will be included on the guarantor (responsible party) statement.

5. Suspension of Billing

In certain situations, continued billing and collection activity may be inappropriate and may be suspended or discontinued. Such situations include but are not limited to: Bad Address ([Section IV\(C\)\(7\)](#)), Bankruptcy Cases ([Section IV\(D\)\(1\)](#)), Deceased Patient ([Section IV\(D\)\(2\)](#)), patient complaint under review or customer service issue, Small Balances ([Section IV\(C\)\(8\)](#)), or ending MassHealth/Medicaid or low-income determinations ([Section V\(E\)\(5\)](#)).

6. Emergent Bad Debt

For those cases where an account is being considered for application to the HSN as Emergent Bad Debt, Acute Care Hospitals and other MGB providers will ensure the following conditions are met:

- The account was subject to continuous collection action for a minimum of 120 days.
- An eligibility inquiry was made to Medicaid Management Information System (MMIS) to screen for coverage.
- The services provided qualify as Emergent or Urgent per the definitions in this policy.
- A final collection notice was sent by certified mail for balances of \$1,000 or more. Accounts that are properly documented as Bad Address accounts may be submitted to the HSN without the mailing of a final collection notice via certified mail provided that 120 days have elapsed from initial billing and that after a reasonable effort, MGB was unable to obtain an updated address. Reasonable attempts will be made to notify MA residents that HSN may provide details of any claims submitted to the patient's employer.

7. Bad Address Returns

Acute Care Hospitals and other MGB providers will make reasonable efforts to track and respond to all patient statements returned by the USPS that are not deliverable. Once an account has been flagged as Bad Address, no further statements or letters will be processed unless a new address has been identified. Bad Address accounts will be flagged in the Registration system to alert any staff involved in the registration process to obtain a new address from the patient. Accounts whose most recent demographic information contains a Bad Address may be referred to outside agencies as Bad Debt for additional follow up except that potential Emergent Bad Debt accounts will be followed for 120 days prior to placement.

8. Small Balance Adjustment

Recognizing the cost of statement processing and collection activities, MGB may suppress statements on accounts below its "small dollar billing" threshold. Similarly, after billing, MGB may limit collection and research activity on small balances and adjust accounts below its "small balance write-off" threshold. In no case will small balance adjustments taken under this section be billed to the HSN. The typical low balance threshold applies to guarantor account balances of less than \$10.00.

9. Surcharge Notice

MGB will maintain a process to identify all patient balances that are subject to the Health Safety Net Trust Fund Surcharge as specified in 101 CMR 614. Surcharge amounts will be billed to the patient, and the funds collected remitted to HSN per their requested schedule, excluding Wentworth-Douglass Hospital

10. No Balance Billing

MGB will maintain a process to identify all patient balances that, per the “No Surprises Act of the 2021 Consolidated Appropriations Act”, would not allow for balance billing. These accounts/balances are related to the following: (1) out-of-network emergency services; (2) non-emergency services by non-participating providers at certain participating health care facilities (unless notice and consent requirements are met), and (3) disclosure of patient protections against balance billing (notice and consent accounts).

- MGB Patient Accounts will not balance bill patients for identified out-of-network provider services when Notice & Consent is not obtained, or any out-of-network ancillary or excluded provider services, accordance with outlined NSA requirements.
- MGB Patient Accounts will not bill patients for amounts above the payer indicated Qualifying Payment Amount (QPA) based patient liability for applicable claims; balances not billable to the patient will be written-off using the appropriate NSA adjustment code.

D. Special Situations – Billing

1. Patient Bankruptcy

MGB will make reasonable efforts to track all Bankruptcy notifications and maintain them on file to ensure that all approved court procedures are followed, including filing of claims with the Court as appropriate or forgiveness of debt.

2. Deceased Patients

When appropriate and cost effective, MGB will perform estate searches, bill estates, and file liens against the estate.

3. Motor Vehicle Accidents (MVA) and Third-Party Liability (MA)

- Reasonable efforts will be made to bill the MVA/TPL carrier to collect any Personal Injury Protection (PIP) amounts available.
- Insurance claims will be processed after the PIP is exhausted.
- MGB may also file a lien against future Bodily Injury payments made by the MVA carrier to the patient if we are able to establish the name of the patient’s attorney managing the claim.
- Claims will not be submitted to HSN until the completion of diligent efforts to collect balances from other parties are exhausted.
- To the degree possible, patients will be reminded that they have a duty to report any potential TPL claim within 10 days of opening a claim to the Office of Medicaid or HSN. Any recoveries received after the submission of a claim to HSN will be offset against the original claim and reported to HSN inclusive of required voids or returns.

4. Motor Vehicle Accidents (MVA) and Third-Party Liability (NH)

Patients with health insurance coverage may choose to have MGB bill their health insurance. Balances billed to the patient will not be subject to any routine discounting or adjustment. The state of New Hampshire cannot bill motor vehicle insurance.

5. Workers Compensation

A Workers Compensation Administration (WCA) claim is generally settled entirely with the WCA carrier if the coverage is valid. MGB will make reasonable attempts to pursue the WCA coverage including filing of legal claims. If there is no WCA coverage, then the claim is managed in the typical manner.

6. HSN Secondary Coverage

MGB will make diligent efforts to limit claims submission to HSN as secondary coverage to those balances which may be covered by HSN, including deductibles, co-insurance, and non-covered services. This includes those cases in which a patient has exhausted their benefit or whose enrollment with the payer was not active at the time the service(s) were rendered.

Claims for services denied due to a technical fault with the claim or other technical denial as outlined in 101 CMR 613.03(1)(c) will not be submitted to HSN. If MGB receives an additional or corrected payment on a claim previously submitted to HSN then a corrected claim will be submitted to HSN, excluding Wentworth-Douglass Hospital

7. Partial HSN Deductible

MGB will bill patients for 100% of their annual Partial HSN Deductible until charges equal to the patient's annual deductible have been billed, inclusive of any balances included in payment plans. Claims will not be submitted to the HSN until the patient's deductible has been satisfied. This includes all satellite facilities and Hospital Health Centers that are operating as part of MGB's license (see [Appendix A](#)).

8. Victims of Violent Crimes

Patients who submit an application to their Attorney General Victim of Violent Crime program should notify MGB's Patient Billing Solutions if they receive a bill. Once MGB is aware an application was submitted, all qualified claims will be sent directly to the Attorney General's Office. If the patient's application is pending, billing to the patient will be suspended until the application process is complete. Payments received from the Victim of Violent Crime program are generally considered to be payment in full.

- To access these programs please visit:
 - MA: www.mass.gov/massachusetts-victims-of-violent-crime-compensation
 - NH: www.doj.nh.gov/bureaus/victims-compensation-program
 - ME: www.maine.gov/ag/crime/victims_compensation

V. Financial Clearance

A. Overview

MGB will make diligent efforts to determine the patient's financial responsibility as soon as reasonably possible during the patient's course of care. Where feasible, Acute Care Hospitals and

other MGB providers will collect co-pays, deductibles, co-insurance amounts, or required deposits prior to any service delivery. Patients, who are members of managed care health plans or insurance plans with specific access requirements, are responsible for understanding and complying with insurance plan requirements, including referrals, authorizations, or other 'network' restrictions. MGB will request any necessary pre-approval, authorization, or guarantees of payment from the insurer whenever possible. Under some circumstances, including Emergent and Urgent service delivery, these referral and authorizations may take place after service delivery.

All patients who incur a balance for services will be informed of the availability of Patient Financial Counseling services to assist them in fulfilling their financial responsibility. MGB will make its best efforts to advise all patients of any significant financial responsibility prior to service delivery to the extent that this information is available. Screening consistent with EMTALA will be completed prior to activities to determine the patient's financial responsibility.

B. Preparation of Estimates

Per M.G.L. c. 111 s. 228 for the state of Massachusetts, Acute Care Hospitals and other MGB providers will provide estimates to patients upon request within 2 business days of the request date for how much a patient may pay for the following (based on patient's insurance plan):

- Estimated duration of hospital stay
- Medical procedures
- Health care services
- Potential out-of-pocket costs

Specialty Care

The department responsible for providing the estimates will vary by location but generally involves the Patient Financial Experience Team and/or Patient Financial Counseling. MGB will maintain a self-service patient estimate process on its website (www.patientgateway.org) for both registered and unregistered patients with access to a broad array of services per the Center for Medicare Services Price Transparency regulations. Additional details regarding estimate processes are in the Estimate Policy and Procedure including the specific requirements to provide a finalized estimate to the patient in writing, along with payment options.

1. Good Faith Estimates

- Patient Access and Experience staff will provide a timely Good Faith Estimate (GFE) to confirm self-pay patients scheduled 10 or more days before service within three business days from the day of scheduling. When scheduled 3 days before service, within one business day after scheduling, and when requested, within 3 days."
- In certain scenarios patient liability above the estimate amount may be written off.
- Good Faith Estimates will include the following:
 - a. Diagnosis code
 - b. Expected service code
 - c. Expected charges
 - d. Patient name and DOB
 - e. Description of primary item or service

- f. Date the item or service is scheduled
 - g. Provider name
 - h. NPI and TIN
 - i. Provider location
- Good Faith Estimates will include the following disclaimers:
 - a. The good faith estimate is an estimate and subject to change
 - b. There may be additional items or services contained in the good faith estimate
 - c. Notification of the patients right to dispute
 - d. The good faith estimate is not a contract

C. Insured Patients

- Acute Care Hospitals and other MGB providers will make every effort to validate the patient's insurance status and per M.G.L. c. 111 s. 228 will notify patient if the provider is out of the patient's benefit plan (i.e., the provider is not contracted). MGB will also assist the patient in complying with the requirements of their health insurance plan, in accordance with the principles previously outlined in [Section III\(D\)](#).
- Whenever possible, this verification will include a determination of the patient's expected financial responsibility, including applicable co-insurance, deductibles, and co-payments, or self-pay balances.
- Where feasible and clinically appropriate, payment of any predetermined amounts (co-payments, fixed deductibles) will be requested from the patient before or at the time of service.
- In some cases, the patient's insurance plan and type of coverage may not allow for an exact determination of the patient's financial responsibility for services at the time of registration. In those cases, MGB may request a deposit equal to the best estimate of the expected patient financial responsibility.
- Patients who are unable to provide payment may be referred to Patient Financial Counseling and the [Financial Assistance and Uninsured Patient Discount Policy](#).

1. Contracted Insurance Plans

MGB contracts with a large number of insurance plans. In those cases, MGB will seek payment from the insurance plan for all covered services.

- Patient payment of all co-payments, deductibles, and co-insurance amounts will be requested prior to service delivery.
- If a particular service is determined by the insurer to be non-covered or otherwise rejected for payment, then payment for that service will be sought directly from the patient in accordance with the relevant insurance contract.
- Whenever possible, MGB will assist the patient in appealing denials or other adverse judgments with their insurance plan recognizing that the insurance plan often requires these appeals to be made by the patient.

2. Non-contracted Insurance Plans

- MGB will extend the courtesy of billing a patient's insurance company in those cases where MGB does not have a contract with an insurer, when authorization has been obtained or the patient is known to have out-of-network benefits.
- While MGB will bill the patient's insurance plan, ultimate financial responsibility rests with the patient or guarantor and the insurer's failure to respond to the bill in a timely manner may result in the patient being billed directly for the services, except in those cases where the patient is protected from collection actions ([Section IV\(C\)\(3\)](#)).
- Balances remaining after any insurance payment may will be billed to the patient.
- Whenever possible, MGB will assist the patient in appealing denials or other adverse judgments with their insurance plan recognizing that the insurance plan requires the appeal to be made by the patient.

3. Notice and Consent

- MGB will provide Notice & Consent to its patients in good faith compliance with the Notice & Consent requirements of the Public Health Service Act (PHS Act), including:
- MGB Patient Access staff will identify nonparticipating provider services subject to No Surprises Act (NSA) Notice & Consent^[1] requirements, and provide and obtain Notice & Consent within the below timeframes in accordance with outlined NSA requirements:
- If the appointment is made 72 hours before services are furnished, Notice & Consent documents will be provided 72 hours before the items or services are to be furnished.
- If the individual makes an appointment for the relevant items or services within 72 hours of the date the items and services are to be furnished, these documents will be provided on the day the appointment is scheduled.
- In a situation where an individual is provided the Notice & Consent documents on the day the items or services are to be furnished, including for post stabilization services, the documents will be provided no later than 3 hours prior to furnishing the relevant items or services.
 - MGB Patient Access staff will not require Notice & Consent for services where Notice & Consent is not applicable, in accordance with outlined NSA requirements (i.e. emergency, ancillary).
 - MGB Patient Access staff will provide the Notice and Consent form physically separate from and not incorporated with other documents.

D. Uninsured Patients (Self Pay)

Patients who do not have health insurance and have not been previously determined to be approved for Financial Assistance, or a Low-Income Patient as further described in [Section V\(E\)](#), will may be asked to provide a deposit in advance of services not required to be performed by EMTALA.

- The deposit will be equal to 100% of the estimated charges for the service to be provided, less any discount (see [Section V\(E\)](#)).
 - In those cases, where a precise estimate of the charges is not possible, MGB may collect a pre-determined deposit amount or otherwise secure guarantees of payment.
- If the patient does not provide the deposit or indicates an inability to pay the deposit, then the patient may be referred to [Patient Financial Counseling](#).

- The Patient Financial Counselor can provide information on any Financial Assistance programs that are available to them.
- Uninsured residents will be offered Financial Counseling to determine their eligibility for any of the available State Programs or other government sponsored programs, as well as providing information to assist the patient in applying for these programs.
 - State Programs include, but are not limited to: Medicaid, ConnectorCare, Children's Medical Security Plan, Health Safety Net.
 - If there is no immediate need to provide services, the admission or outpatient service may be deferred or canceled until such time as the patient is able to pay, make suitable financial arrangements, obtain insurance, or become enrolled in a financial assistance program that will cover the service.

E. Low Income Patients (Massachusetts Residents)

1. Definition and Eligibility

- Low Income Patients are defined as meeting the criteria in MA 101 CMR 613.04(1).
- This generally includes patients who are residents of Massachusetts who have applied for coverage with EOHHS and have a verified MA Modified Adjusted Gross Income (MAGI) equal to or less than 300% of the Federal Poverty Guidelines (FPG).
- A Patient's eligibility status for coverage under any program (Medicaid, , Health Safety Net, and Children's Medical Security Plan (CMSP) under 300%) will be verified at time of registration.
- The limitations outlined in this section for Low Income Patients are required for services at Acute Care Hospitals (see [Appendix A](#)) and Federally Qualified Health Centers in Massachusetts and generally exclude services at affiliated practices, hospitals in New Hampshire, McLean Hospital, and the Spaulding Rehabilitation Network. Discounts for services at those entities are included in the [Financial Assistance and Uninsured Patient Discount Policy](#).

Low Income Patients (New Hampshire Residents)

- New Hampshire gross income is equal to or less than 250% of the federal poverty guidelines
- WDH Dental Center gross income is equal or less than 300% of the federal poverty guidelines

1. Service Limitations

Patients who are identified as Low-Income Patients will, to the extent possible, be provided services consistent with the coverage guidelines of either HSN or Medicaid including "eligible service" limitations (under state regulations and the applicable drug formulary).

2. HSN Medical Hardship

A Massachusetts resident at any income level may qualify for HSN Medical Hardship if their allowable medical expenses exceeded the family's income beyond their ability to pay for eligible services. This retrospective program is per regulations, limited in scope, is a onetime annual determination, and is not a coverage category (101 CMR 613.05). This program may only be applied for after service delivery when the patient has incurred a financial liability.

a. **Expense Qualification**

The type and amount of allowable medical expenses are specified in 101 CMR 613.05. Paid and unpaid bills with service dates up to 12 months prior to the date of application may be submitted with a limit of 2 applications within a 12-month period.

b. **Application Process**

MGB will assist the patient in the collection of all applicable information and will submit Medical Hardship applications to HSN for review and approval or provide patient with information necessary to apply. Patients have the responsibility to collect and submit documentation of all qualifying medical expenses. MGB is required to submit applications to HSN within 5 days of receiving all documentation and verifications from the patient.

c. **Determination**

HSN will determine the patient's qualification for the program and will notify MGB as to which bills are the patient's responsibilities and which bills may be submitted to the HSN. Determination of Medical Hardship is limited to those bills that were included with the application. There is no eligibility period and bills may only be used once to support an application.

d. **Protection from Collection**

All collection actions will be discontinued for all balances that are determined by HSN to be eligible for coverage under Medical Hardship. This includes balances that may have been assigned to an external agent or collection agency working on behalf of MGB. If MGB fails to apply within 5 days after receiving all verifications from the patient, then all balances which might have qualified under Medical Hardship are protected from collection actions.

3. **Low Income Patient Financial Responsibility**

The financial responsibility for a Low-Income Patient is limited to copayments (from any payer except Medicare) or deductibles determined by HSN.

a. **Pharmacy Co-Payments**

Low Income patients over the age of 18 are responsible for co-payments for pharmacy services. Consistent with general policies, co-payments will be requested at time of services. Unpaid co-payments will be treated as a patient liability and collected in accordance with the typical self-pay collections process.

b. **Deposits for Low Income Patients designated as Partial HSN or Medical Hardship**

Deposits will be requested from these patients provided this is the primary coverage for the open balances for all Non-Emergency or Non-Urgent medically necessary services ([Section III\(B\)\(2\)](#)). The current status of the patient's annual family deductible will be reviewed, and a deposit of the patient's annual deductible, or a Hardship contribution, will be collected.

c. **Payment Plans**

Low Income Patients will be notified of the availability of payment plans to satisfy all open balances per the terms specified in [Section VI\(B\)](#).

d. Non-Eligible Services

Low Income Patients will be required to pay for any Non-Eligible Services, including but not limited to Infertility Services, Cosmetic Services, or non-medically necessary podiatry services ([Section III\(B\)\(2\)](#)), in advance, provided that the patient is informed of the maximum cost of these services and signs an acknowledgement that the services are not covered by HSN or any other Massachusetts assistance programs. Services will be deferred until payment is made according to the guidelines in [Section III\(B\)\(2\)](#).

e. Behavioral Health and Rehabilitation Hospitals

Financial responsibility for these services are covered in the [Financial Assistance and Uninsured Patient Discount Policy](#).

4. Pending Status Determinations

Patients for whom MGB has submitted an application for a state or other government sponsored program will generally have their bills held for up to 30 days pending determination. After 30 days they may be processed as Self Pay until a determination has been made. Requirements for deposits may be waived pending a determination by a Patient Financial Counselor that a patient's application is complete and expected to be approved.

F. Special Situations for Financial Clearance – Registration and Patient Financial Responsibility

Under some circumstances, additional information or procedures may be needed to support processing of the patient's claims.

1. Workers Compensation

Services related to industrial accidents must be appropriately identified at time of registration. Additional information required from patient includes the date and time of accident, employer name and phone number, and employer's workers compensation carrier and phone number. (See [Section IV\(D\)\(5\)](#) regarding submission of claims to Workers Compensation carriers prior to HSN submission.)

2. Motor Vehicle Accidents (MVA) and Third-Party Liability

Services related to a motor vehicle accident or other third-party liability should be appropriately identified at time of registration. Diligent efforts will be made to collect additional information that is required for submission of MVA claims including the date and time of accident, the location for third party liability cases, any known automobile insurer (except in New Hampshire (NH) where MGB may not submit claims to the MVA carrier), and the name of any attorney associated with the claim (if it is available). (See [Section IV\(D\)\(3\)](#) regarding submission of claims to MVA liability carriers in MA prior to HSN submission.)

- In NH, the claim will be filed with the patient's medical insurance or billed directly to the patient based on the patient's direction. Services billed to the patient for an MVA are not subject to discounts (See [Section IV\(D\)\(4\)](#)).

3. Victims of Violent Crimes and Violence Against Women (MA)

Services related to victims that fall under these categories should be appropriately identified at the time of registration, including creation of any required special coverage when indicated. In some cases, there are limited funds available from the MA, NH, and ME Attorney General's office to offset medical expenses that are not otherwise covered by medical insurance or the Health Safety Net. VVA victims should not be billed for any qualified services.

4. Health Information Technology for Economic and Clinical Health Act of 2010 (HITECH)

Provides patients the right at the time of service to request that their Patient Health Information (PHI) regarding a specific item or service not be sent to their health insurance for purposes of payment.

- The patient is expected to pay any outstanding balance in full at time of service or upon receiving statements.
- HITECH only allows the patient to not have insurance billed.
- HITECH prevents any release of information to a third party on the identified visit.
*It does not negate the patient's financial responsibility for payment of accounts.

5. HSN Confidential Applications

Confidential applications may be submitted under two circumstances.

- Minors: Confidential applications may be submitted for minors presenting for family planning services and services related to sexually transmitted diseases. These applications may be processed under the minor's income without any regard to the family income.
- Battered or Abused individuals: These individuals may also apply for HSN coverage on the basis of their individual income. These patients may be approved for the full range of services covered by HSN.

6. Undocumented Persons

Patients may be concerned about the immigration implications of applying for Low Income Patient status.

- Patients with limited means should be encouraged to apply for a state or other government sponsored program.
- If patients continue to express concern, patients may be referred to outside agencies for counsel.
- Patients refusing to apply for assistance will continue to be treated as self-pay.
- Urgent and Emergent services (including up to two weeks of drugs required to respond to immediate threats to patient's health) should continue to be provided ([Section IV\(B\)\(1\)](#)).
- Non-urgent, non-emergent services ([Section III\(B\)\(2\)](#)) may be deferred or canceled until such time as the patient is able to pay, make suitable financial arrangements, obtain insurance, or become enrolled in a financial assistance program that will cover the service.

7. Research Studies

Services related to research studies should be identified at time of registration for that service to ensure that charges for these services are submitted to the designated research fund.

Patient's health insurance may be billed for standard of care charges related to the study, and the patient may be billed for co-pay, deductible, co-insurance balances.

8. Organ Donors

MGB will identify organ donors at the time of service and ensure that claims for these services are applied to the appropriate insurance or other funding source.

9. International Patients

In addition to following the procedures stated for Insured ([Section V\(C\)](#)) and Uninsured patients ([Section V\(D\)](#)), MGB will make every reasonable effort to gather local and permanent address information for residents of foreign countries and take whatever appropriate additional actions are needed in order to secure pre-payment for all uninsured services.

G. Serious Reportable Events (SRE)

MGB maintains compliance with applicable billing requirements, including the Department of Public Health regulations (105 CMR 130.332) for non-payment of specific services or readmissions that MGB determines was the result of a Serious Reportable Events (SRE). SREs that do not occur at Acute Care Hospitals and other MGB providers (see [Appendix A](#)) are excluded from this determination of non-payment. MGB also does not seek payment from a low-income patient determined eligible for the Health Safety Net program whose claims were initially denied by an insurance program due to an administrative billing error by MGB. MGB also maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws.

H. Bad Debt Placement

Accounts will typically be written off to Bad Debt when internal collection efforts have been exhausted. This typically occurs after the account has completed its 120-day billing cycle ([Section IV\(B\)](#)). Some accounts may be placed earlier than 120 days due to mitigating circumstances such as the inability to locate the guarantor (e.g., bad address). Accounts in Bad Debt will generally receive additional collection effort primarily by external Collection Agencies or collection attorneys. MGB will ensure that all follow-up of Bad Debt, whether by internal staff or an external agency, adheres to the following:

1. Credit Reporting

MGB and its agents do not report patient Bad Debt to any credit bureau. MGB and its agents may utilize the services of a credit bureau to identify the credit rating of a patient with a view to determining the patient's ability to fulfill their financial obligations.

2. Litigation

MGB and its agents may pursue litigation against a patient to secure a court judgment for debts owed to MGB. In no case shall a writ of capias (known as a "body attachment") nor garnishment of wages will be used as part of a collection effort.

3. Property Liens

MGB will only pursue the attachment, execution, and sale of property after the patient has been screened for financial assistance and upon the review and approval of the Acute Care Hospital or other MGB Provider's CFO. If the patient has been designated by the Office of Medicaid as Low Income or qualifying for any assistance program, then MGB will not seek legal execution against the personal residence of a patient or Guarantor without the specific approval of the Board of Trustees.

4. Collection Agencies

- Any agency seeking to collect patient balances on behalf of MGB will be required to conform to this Credit and Collection Policy.
- Any substantive patient complaints will be reported to MGB for review and tracking.
- All agents will fully comply with applicable Federal Fair Debt Collection regulations as well as debt collection regulations that may be determined by the Massachusetts Attorney General or the appropriate state the service was rendered in.
- All agencies will report any collections or other account actions, including the decision to cease collection efforts, on a timely basis.
- In general, agencies will cease collection efforts on any account placed with them as soon as they determine that there is no potential for collection and when there has been no action or payment on the account for no more than one year.

VI. Payment Arrangements

A. Overview

Payments may be made in a variety of settings at all Acute Care Hospital or other MGB Provider. Payment arrangements for pre-service collections, payment plans, or consideration of partial payment of deposits. All payment arrangements will conform to pre-determined criteria.

1. Forms of Payment

- Prepayments may be made by certified/bank check, wire transfer (wire transfer fees may apply), or credit/debit cards. Cash is not accepted at most hospital locations. Personal checks from U.S. banks are typically accepted for balances of less than \$5,000 unless there is a history of checks failing for insufficient funds. Personal checks may be requested sufficiently in advance of a scheduled service in order to allow time for verification of the check. Patients who have a history of bad debt may be reviewed individually to determine the appropriate mode of payment.
- Payments by personal check should be made to the remit address on the patient statement including full account number in order to avoid delays or incorrect posting of the funds.
- Electronic billing and payment: Many MGB locations provide electronic access to statements and payment of those statements electronically using credit/debit cards.
- If any pre-payments are being appealed with their health insurance, pre-payments would not be refunded until payments are received by the health insurance in full.
- Payments are accepted by calling the Patient Billing Solutions Call Center or other designated Customer Service Centers.

- MGB will maintain a process to track 'bad/bounced' checks with non-sufficient funds and reverse any payments that may have been applied to the patient's account. Submission of a 'bad/bounced' check with non-sufficient funds may be grounds for applying the account to Bad Debt.

2. Currency

Unless otherwise agreed to, payment will be made in U.S. Currency. Payment made in non-U.S. currency will be applied at the conversion rate specified by MGB's bank, less any conversion fees.

B. Payment Plans

Interest free payment plans are available to all patients on request. Final acceptance of a payment plan is subject to a complete review of the patient's status and payment history. Payment plans can be set up on Patient Gateway or by contacting Patient Billing Solutions at (617) 726-3884. Patient Billing Solutions will process and monitor all patient payment plans. Plans will generally cover open balances at all MGB locations ([Appendix A](#)).

No interest will be charged on balances where a patient has agreed to a payment plan and the patient is current with payments.

Plans will be reviewed on a regular basis to ensure that all payments are up to date. If a patient misses two payments, MGB may place the account in Bad Debt. Upon notification from the patient of changed financial circumstances, MGB may reevaluate the patient's outstanding payment obligation.

Balances less than \$100.00 will automatically be added to an existing payment plan, if the monthly payment does not increase, but can extend the term of the payment plan. If the monthly payment will increase and/or new balance(s) are greater than \$100.00 these balances will not be automatically added to an existing payment plan. The responsible party can add new balances to an existing payment through the Patient Gateway portal or by contacting Patient Billing Solutions at 617-726-3884.

1. Payment Plans for HSN Partial Deductibles and Medical Hardship

A initial payment of the lesser of \$500 or 20% of the deductible balance may be required inclusive of all deposits accepted prior to service delivered in non-urgent/non-emergent events.

VII. Credit Balances and Refunds

Generally, MGB will refund to patients any credit balances, which may result from excess funds having been collected from the patient. In cases where efforts to refund a patient/guarantor credit balance are unsuccessful, MGB will remit credit balances to the Treasurer of the Commonwealth of Massachusetts in accordance with the state's Abandoned Property regulations.

1. Overpayments and credits will first be applied to any outstanding open balances with any other Mass General Brigham affiliated entity, including accounts in Bad Debt before processing any refunds, except for Cosmetic, Dental, IVF, McLean, and Mass Eye and Ear. Credits will be refunded

in the original form of payment. A check can take up to 30 days from when the check is cleared by the bank. Check payments are refunded back to the responsible party for amounts \$999.99 and under. Any check payment received \$1000 and over will be issued back to the Payee when check documentation is available. If check documentation is not available, the refund will be issued to the responsible party of the account.

2. Credit Card Payments made using a closed card or expired token: The payment gateway will not process a credit card refund if the original payment is more than 18 months old or if the credit card on file is expired. These refunds must be made using a check.
3. Wire transfers require additional documentation that may require that the refund is fully approved. Verifications usually require that the funds be returned to the same bank account that the funds were disbursed from. This verification typically accompanies the request. This includes Flywire refunds as well.

Refund for a Deceased Patient: Refunds will be issued as follows:

1. Credit Card: Issued to the credit card if the card is still able to accept the refund.
2. Estate: If an estate has been opened and is still active, then the refund will be preferentially issued to the estate.
3. If the balance is under \$500 and there is no estate, then the refund may be issued to the surviving spouse provided that the spouse is identified as the next of kin on file.
4. If there is no estate and the balance is \$500 or more, then the identified next of kin/spouse will be asked to complete an affidavit prior to issuance of a refund.
5. If there is no estate and the balance is \$500 or more, and a family member other than a spouse calls, they need to open up a Voluntary Estate in Probate.

Appendix A: Affiliated Mass General Brigham Entities

This policy applies to the following Mass General Brigham entities:

Acute Care Hospitals

Massachusetts General Hospital (MGH)
Brigham and Women's Hospital (BWH)
North Shore Medical Center (NSMC)
Newton-Wellesley Hospital (NWH)
Brigham and Women's Faulkner Hospital (BWFH)
Martha's Vineyard Hospital (MVH)
Nantucket Cottage Hospital (NCH)
Cooley Dickinson Hospital (CDH)
Wentworth Douglass Hospital (WDH)
Massachusetts Eye and Ear (MEE)

Behavioral Health Hospitals

McLean Hospital (MCL)

Post-Acute Hospitals

Spaulding Rehabilitation Hospital Boston (SRH)
Spaulding Hospital for Continuing Medical Care Cambridge (SHC)

Spaulding Rehabilitation Hospital Cape Cod (SCC)

Physicians Organizations

Massachusetts General Physicians Organization (MGPO)

Brigham and Women's Physicians Organization (BWPO)

North Shore Physicians Group (NSPG)

Newton Wellesley Medical Group (NWMG)

Cooley Dickinson Medical Group (CDMG)

Nantucket Medical Group (NMG)

Mass Eye and Ear Associates

Wentworth Health Mass General Brigham (WHP)

Mass General Brigham Community Physicians - wholly owned groups

Pentucket Medical Associates (PMA)

Mystic Health Care

Home Care

Mass General Brigham Home Care

Mass General Brigham Ambulatory Care

Mass General Brigham Urgent Care

Note that physicians associated with these entities, but who bill "privately" are encouraged, but not required, to follow this policy. Details may be found on the [Mass General Brigham Provider Affiliate List](#)

Appendix B: Financial Assistance Application

The Mass General Brigham Financial Assistance application can be found here:


<https://www.massgeneralbrigham.org/content/dam/mgb-global/en/patient-care/patient-and-visitor-information/financial-assistance/documents/assistance-information/english/financial-assistance-application-english.pdf>

Financial Assistance | Wentworth-Douglass Hospital

Wentworth-Douglass is committed to providing quality healthcare services to everyone in our service area regardless of ability to pay.

<https://www.wdhospital.org/wdh/patients-and-visitors/billing-and-insurance/financial-assistance>

The application is available in 10 languages on www.massgeneralbrigham.org: English, Arabic, Chinese, Haitian Creole, Indonesian, Khmer, Portuguese, Russian, Spanish, and Vietnamese.

 **Mass General Brigham**

Mass General Brigham Financial Assistance Application

Please print out and complete all sections of the application that apply to you. **This application cannot be completed electronically.** Please read all instructions before completing application.

This application is used to evaluate your eligibility for financial assistance on medical bills from Mass General Brigham providers. You can use this application to apply for help with health care bills from any of the following Mass General Brigham entities:

Massachusetts General Hospital	Massachusetts General Physicians Organization
Brigham and Women's Hospital	Brigham and Women's Physicians Organization
Cullen Hospital	North Shore Physicians Group
Newton-Wellesley Hospital	Newton-Wellesley Medical Group
Brigham and Women's Faulkner Hospital	Martha's Vineyard Hospital
Mass Eye and Ear	Mass Eye and Ear Associates
Harvard Cottage Hospital	Harvard Cottage Medical Group
Crofton-Cookman Hospital	Crofton-Cookman Medical Group
Squidley Rehabilitation	Miculan Hospital
Wentworth-Douglass Hospital	Wentworth Health Associates

Mass General Brigham Financial Assistance is not considered a substitute for enrolling in any available health insurance program or assistance plan. While the program covers all Medically Necessary Services, discounts vary based on the type of services provided and the location that the care was provided. Please refer to the complete policy on our website for the details on what is covered. A partial list of services that are typically excluded follows:

- Out of Network Dentals
- Cosmetic Surgery
- Infertility Services (ART & IVF)
- Most non-medically necessary care including Gastric Bypass Services
- Patient Convenience Items including premium accommodations
- Services that are designated as "Self-Pay Only"

Failure to apply for a government assistance program that you potentially qualify for could result in a delay or denial of your application. If you need help applying for government assistance programs, one of our Mass General Brigham Financial Navigators can help.

You must fully disclose any other coverage, third-party liability claim, motor vehicle coverage or workers compensation coverage to be considered.

If you have any questions on this application, please contact [Patient Financial Services](#) at your hospital or call (617) 726-3884.

Rev 11/23 Page 1 of 7

Appendix C: Reporting, Audit, and Compliance with Regulations

These policies are intended to help ensure compliance with applicable state regulations in New Hampshire and Massachusetts including the criteria for credit and collection policies under MGL c.58 and related regulations specifically promulgated by the MA Executive Office of Health and Human Services, 101 CMR 614 and 101 CMR 613 (Health Safety Net), hereafter referred to as "State Regulations". In addition, this policy addresses the requirements for The Medicare Provider Reimbursement Manual (Part 1, Chapter 3) the Centers for Medicare and Medicaid Services, Medicare Bad Debt Requirements (42 CFR 413.89 and the Internal Revenue Code Section 501 (r) as required under the Section 9007 (a) of the Federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

MGB will comply with all reporting requirements as defined by MGL c. 118G and related 101 CMR 613, 614 and associated Administrative Bulletins. MGB will maintain auditable records of activities made in compliance with the criteria and requirements of 101 CMR 613 and 101 CMR 614. MGB will file this Credit and Collection Policy electronically with the Office of Medicaid, Health Safety Net as required when the policy is changed or when there are regulatory changes promulgated by the Office of Medicaid, Health Safety Net mandating a new policy submission.

Reference:

MA Regulations 101 CMR 613, 614 and MGL c. 118G.

IRS 501 (r) c