Administrative Policy: BILLING AND COLLECTION POLICY

SCOPE: This policy applies to all SRHS entities.

SCOPE EXCLUSIONS: None

AUTHOR: Finance

PURPOSE:

This policy provides guidance for circumstances in which Saint Raphael Healthcare may provide care at no cost or partial cost to the patient in conjunction with the patient's ability to pay for services rendered along with guidelines for uncollectible patient accounts, bad debt and small balance write-offs.

POLICY:

The SRHS Financial Assistance Program reflects SRHS mission of caring for all in need, with respect, dignity, justice and excellence; regardless of race, creed or color and ability to pay.

Collection activities on patient accounts will be conducted in accordance with established guidelines that secure the optimum prospect for realization of such accounts. The outlined guidance is applicable to Patient Accounting staff, Outsource vendors and Collection agencies for the processing and collection of patient accounts receivable. Collection activity should be maximized to secure account receivable balances and to control the losses and expenses associated with uncollectible accounts. Uncollectible patient balances will be written-off based on proper authorizations.

PROCEDURE

Saint Raphael Healthcare System will provide Financial Assistance to low-income, uninsured, and underinsured patients. This service, along with other community benefit services, is essential to fulfilling the mission of SRHS.

Individuals identified as uninsured/underinsured and who are unable to access state entitlement programs shall be eligible for financial assistance based on established criteria. Eligibility criteria will be based upon the Federal Poverty Guidelines, which will be updated annually in conjunction with published updates by the United States Department of Health and Human Services.

Confidentiality of information and individual dignity will be maintained for all. The handling of personal health information will meet the requirements of applicable federal and state laws.

Eligibility Criteria

A. Financial Assistance - All patients will be offered the opportunity to apply for financial assistance and/or free bed funds (See Policy 4.7). Identified self-pay patients will be given information on financial assistance and free bed funds during the registration process or at such time as it is determined that the patient will have limited funds to pay for services.

B. Financial Assistance Application - A written Financial Assistance Application (attached), along with all supporting data is required to verify financial assistance eligibility.

C. Eligibility Determination - Once an eligibility determination has been made, a notification letter will be sent to the patient advising of the decision of Saint Raphael Healthcare System.

D. Complete Financial Assistance - A patient's annual family income must be less than or equal to 250% of the current year's Federal Poverty Guidelines in order to be eligible for complete financial assistance.

E. Partial Financial Assistance - A patient's annual family income must be greater than 250% and is less than or equal to 400% of the current year's Federal Poverty Guidelines in order to be eligible for partial financial assistance. Partial financial assistance means the patient will be charged only the cost of services rather than the hospital's published charges.

F. Assets - Patient assets may not exceed $2500.00 per person listed in the household in order to be eligible for financial assistance. The limitation on patient assets excludes retirement accounts.

G. Eligibility Period - The financial assistance period of eligibility covers accounts in a current status from the date of the initial eligibility determination. Current status means the account has not been sent to a collection agency.

H. Documentation - All applications must be accompanied by:
- Proof of income
- A patient's employment status and earnings documentation. .

Credit reports may be used, when appropriate, to verify an individual's financial circumstance.

I. Homeless Patients- Patients without a mailing address or residence may be classified as homeless and qualify for financial assistance.

J. Collection Agency- Collection efforts against uninsured patients will be undertaken only in accordance with the policy "Protection for Uninsured Patients" (Policy 4.20). Collection agency accounts meeting financial assistance criteria will be returned to Patient Accounts.

K. Special Circumstances- Deceased patients without an estate or 3rd party coverage will be eligible for financial assistance. Patients in bankruptcy and those who are eligible for State Medical Assistance, but are subject to a spend down, may also qualify for financial assistance.

L. Time Requirements for Charity Determination- All financial assistance applications will be reviewed in a timely manner. In some cases, eligibility is readily apparent and a determination can be made before, on, or soon after the date of service. In other cases, a more thorough investigation may be necessary to determine eligibility (particularly when limited information is provided by the patient).

M. Authorization for Financial Assistance Adjustments- Saint Raphael Healthcare System
Maintains an approval level matrix as follows:

PFS Manager - Up to $25,000
PFS Director - Up to $50,000
SRHS CFO - Above $50,000

N. Record Keeping- Documents collected from potential financial assistance patients will be retained for audit purposes. Access is limited to financial counselors and management.

O. Saint Raphael Healthcare System Financial Assistance Leadership Team/Committee-The SRHS Leadership Team shall consist of a chairperson and committee representatives from various hospital departments whose primary role is to oversee special circumstances cases.

EXCLUSIONS:

This Policy applies to services rendered in all Saint Raphael Healthcare System facilities and affiliates. It does not apply to services rendered by any independent physicians. This policy does not apply to "elective procedures" (including, but not limited to, cosmetic surgery). For scheduled registrations, patients will be expected to

pay for services rendered. The policy also excludes individuals who did not follow insurance policy rules, (i.e., completing COB's, obtaining authorizations and referrals). **Patients refusing to provide all necessary documentation to process a formal application will be denied financial assistance.**

Saint Raphael Healthcare System Financial Assistance Leadership Team must approve any modification of this policy in writing.

DEFINITION

"Patient Bad Debt" is defined as the balance that is due from an account guarantor who has the ability to pay but does not. It is assumed that account guarantors have the ability to pay their portion of the bills for services rendered unless they explicitly indicate otherwise. Bad Debt must be reported as an expense item, for financial statement purposes and not as deduction to gross patient service revenue.

BACKGROUND – PATIENT BILLING

Generally, the patient is responsible for the full amount of their bill. However, it is the policy of the Hospital that all self-pay patients lacking the financial resources to pay the full amount of the bill are eligible for Financial Assistance consideration.

Pure Self Pay Patient Bill/Statements Generated

All self-pay patients/guarantors will be sent a statement, the first day following the 10th day after discharge contingent upon medical records requirements and other edit requirements being fulfilled.

Itemized bills will not be sent to patients unless requested. When requested, itemized bills will be mailed to patients within 24 hours of their request or patients are directed by their statements to review their itemized bill on line.

Statements will not be mailed if the account balance is less than $10.

Self Pay Statement Cycle

Following the initial bill sent to self-pay patients/guarantors, the Hospital will generate and send out a Second Statement 30 days later. At day 61, the Hospital will outsource the account to an external vendor who will continue to follow-up with the patient/guarantor on behalf of the Hospital, beginning with phone calls and then follow up with a series of letters over the course of 60 days. In the event that the external vendor is unable to contact the patient due to lack of a phone number on the data file transmission, an information letter will be mailed in lieu of the 2 phone calls.

At the end of 120 days, if the account remains unpaid, it will be written off to bad debt and turned over to a collection agency for additional collection efforts.

Residual Self Pay

After the primary insurance has paid, based on a closed IAR, accounts that do not have any other insurance coverage will automatically be mailed a statement 10 days after the IAR has been closed. Statements will follow the same process as outlined above from point of the initial bill.

Interruption or Stoppage of Statement Cycle

The cycle above will only be stopped or interrupted for the following occurrences:

Full payment is received
Receipt and certification of third party coverage
Payment/installment/financial assistance arrangements
Evidence that the account is uncollectible or other legal consideration results in expedited referrals to collection agencies or attorney
Return mail and no address can be found
Accounts involving an Estate

Budget Payments

Prior to an account being referred to a collection agency, an installment agreement for balances above $75.00 may be negotiated where the patient or guarantor provides financial information indicating the reason for the inability to immediately pay the bill. Budget Plans should not exceed two years in length or an installment amount less than $25.00 exceptions may be made with approval of the Director of Patient Accounts or the Customer Service Manager. Finance charges will not be assessed.

When a budget plan is established, a statement is generated and mailed to patient and/ or guarantor showing the installment amount .The first payment will be due in 30 days. If a payment is received, the budget billing cycle will reset itself monthly and a statement will be produced that will reflect the overall balance due as well as the current monthly amount due. In the event that a monthly payment is missed, the account will follow the cycle below:

Days after Initial Statement

30 Payment Due
60 Delinquent Statement
90 Budget Cancelled
120 Write Off to Collection

Small Balance Write-Offs

Accounts with balances less than $10 in a self-pay financial class will be automatically written off to a small balance write-off code.

Accounts whose balances are less than $24.99 will be written off to a small balance allowance upon completion of the statement cycle unless the Manager, Customer Service/Credit determines that additional in-house work is required.

Collection Agencies/Legal Actions

After 120 days, accounts that remain unpaid are automatically forwarded onto a collection agency. Exceptions to this process are to be approved with the Manager, Customer Service or the Director of Patient Accounts and so noted in the account history. All agencies must adhere to federal guidelines as established in the Fair Debt Collection Act as well as any additional State of Connecticut requirements. Collection agencies will be held accountable to be effective as well as courteous to patients. As a general rule, the Hospital will maintain relationships with two collection agencies. Their performance will be monitored and evaluated on a regular basis.

Credit reporting agencies will not be notified of accounts written off as bad debts.

Collection Agencies may, after approval of the Director of Patient Accounts or the Manager of Credit/Customer Service, refer an account to their attorney for additional collection efforts. These efforts include and are limited to liens on property, judgments and wage garnishments. Collection agencies may not initiate foreclosure proceedings as a means to collect a debt. The approval to pursue further legal activities is contingent upon a thorough review of the individual account as well as previous patient history to ensure there is no evidence of improper insurance billing. Agencies should be informed that the hospital's financial assistance primarily is income based and therefore the existence of tangible assets without income above the financial assistance thresholds must not result in a lien on property, unless with express written permission from the Manager of Customer Service or Director of Patient Accounts.

The Director of Patient Accounts or the Manager of Customer Service may approve accounts to be referred directly to an attorney for legal action without the involvement of Collection agencies. These accounts typically have balances in excess of $10,000 and involve motor vehicle accidents, disputed Workers Compensation claims, probate conservatorships, third-party litigation, or a patient's attorney.

Criteria for Bad Debt Recommendation

Upon recommendation for bad debt write off, accounts must have been billed over a period of 120 days (this may include the time the account was outsourced to the early out external vendor)

and been maintained according to departmental guidelines. Accounts recommended for bad debt may be forwarded to an external collection agency for additional collection efforts. Medicare and non-Medicare accounts must follow the same standard procedures. For Medicare purposes, accounts cannot be placed on the Medicare cost report until collection activity is ceased (including active collection efforts at the collection agency).

1. Account documentation must validate that reasonable collection efforts have been exhausted and completed.

2. Accounts with balances less than $10 in a self-pay financial class will be automatically written off to a small balance write-off code. Accounts whose balances are less than $24.99 will be written off to a small balance allowance upon completion of the statement cycle unless the Manager, Customer Service/Credit determines that additional in-house work is required.

Write-off Controls

1. Placements of accounts to the external agencies after 120 days of internal collection and early out collection are to be monitored by a Director of Patient Accounts or the Manager of Credit/Customer Service.

Justification for not referring accounts to external collection agencies should be presented, in writing, for approval by a Director of Patient Accounts or the Manager of Credit/Customer Service. Or, the account meets one of the following criteria: no demographics in the system-patient was seen but not registered; bankruptcy or the patient is declared homeless.

2.

   a. Accounts (both Medicare and non-Medicare) are to be returned to the hospital from the external collection agencies and written off to bad debt uncollectible after a period of six months where the agencies has not been able to contact the patient or the patient is deemed judgment proof. A patient can be judgment proof due to employment status or the absence of assets.

FINANCIAL ASSISTANCE DISCOUNT - BASED ON 2010 FEDERAL INCOME GUIDELINES
Current Hospital of Saint Raphael Policy

Federal Register: 1/23/09 (CMS has extended the 2009 Poverty Guidelines through May 31, 2010)

	ANNUAL INCOME									
	Family Size	Fed Poverty Guidelines		Full Financial Assitance 101% - 250% FPL 100% Discount			Reduced Financial Assistance 251% - 400% FPL 61% Discount			
	1	$	10,830	$	10,831	$ 27,075	$	27,076	$	43,320
	2	$	14,570	$	14,571	$ 36,425	$	36,426	$	58,280
	3	$	18,310	$	18,311	$ 45,775	$	45,776	$	73,240
Family of 4	***4***	***$***	***22,050***	***$***	***22,051***	***$ 55,125***	***$***	***55,126***	***$***	***88,200***
	5	$	25,790	$	25,791	$ 64,475	$	64,476	$	103,160
	6	$	29,530	$	29,531	$ 73,825	$	73,826	$	118,120
	7	$	33,270	$	33,271	$ 83,175	$	83,176	$	133,080
	8	$	37,010	$	37,011	$ 92,525	$	92,526	$	148,040

Note: Families with more than 8 member, $3,740 is added per person

Last Update: 5/06/10

Administrative Policy: FINANCIAL ASSISTANCE PROGRAM 4.6

Effective Date: 3/2000

Revision Dates: 3/2007, 3/2008, 3/2009

Review Dates: 3/2007, 3/2008, 3/2009

I. SCOPE

- This policy applies to the Hospital of Saint Raphael

II. EXCLUSIONS FROM SCOPE

-None

III. POLICY AUTHOR

-Patient Accounting Department

IV. PURPOSE

- To identify the guidelines of application for financial assistance programs ("FAP") and charity care.

V. POLICY

- Guidelines for patients and their families to apply for FAP will be administered as defined by each program's criteria.

VI. PROCEDURE

- The procedures to be followed related to FAP and charity care as follows:
  - Patients wishing to apply for FAP must apply for City/State/Husky first and receive a denial. Refer all patients who wish to apply for State/City/Husky assistance to the Welfare Office on 194 Bassett Street, New Haven.
  - For a patient who is female, age 40 or over, has no health insurance, or the patient's health insurance does not cover Pap and pelvic tests, clinical breast exams, or diagnostic services, refer the patient to the Connecticut Breast & Cervical Cancer Early Detection Program at 867-5436 for more information. If the patient qualifies for this program, they can apply for the FAP and/or one of the free Bed Funds for services not covered under this grant.

- If the patient is a pregnant non-citizen or is a citizen and is not covered under any health insurance (or health insurance that will not cover pregnancy or has high deductibles), the patient is to be referred to the Husky representative at Gateway or at the Hospital for assistance. If the patient does not qualify for the Husky program, they can apply for the FAP and/or one of the free Bed Funds for services not covered under Husky.
- The patient will be requested to contact a financial counselor when they receive a copy of any denials for any of the programs noted above. The financial counselor will then provide a FAP application to the patient. If the patient is denied City/State/Husky because the patient did not complete the City/State/Husky application process, the patient may apply for one of the Hospital's discount program or free Bed Funds.
- Patients who are true self pays and want to apply for some type of assistance but do not want to apply for City/State assistance should be directed to apply for the State of Connecticut Financial Assistance Program Discount to Hospital Costs or to other SRHS programs.
- Patients who may qualify for free Bed Funds will need to complete the free Bed Fund Application.
- Patients who are put on asset spend-downs may also apply for financial assistance or one of the Bed Funds.

The matrix that is attached as pages 3 of this policy should be used as a tool for identifying which program guidelines, application processes, and income levels apply.

VII. OTHER INFORMATION

-FAP application, Bed Fund Application

VIII. ATTACHMENT

-Financial Assistance Program (FAP) Guidelines.

IX. REFERENCES

-None

Hospital of Saint Raphael Financial Assistance Programs

Program Guidelines	Application Process Guidelines	Federal Poverty Income Levels 2009
PLAN 1: HSR FINANCIAL ASSISTANCE PROGRAM (FAP 100%) Patients whose income levels are at or less than 250% of federal poverty guidelines are eligible for discounts up to 100% of billed charges, if they apply for general assistance/medicaid/husky coverage and present denials and meet other financial tests. See application process for all applicable guidelines. The discount will also apply to patient co-pays, co-insurance and exhausted benefits. This discount is available to only Connecticut residents. **PLAN 1B: HSR MATERNITY 100% FAP**	To qualify for discount, the following process must be followed: • Must apply for general assistance, Medicaid, or Husky program coverage and present *valid* denial. Denial for failure to provide information requested by the State is not acceptable. • Completion of FAP application. **Must provide proof of income** (W-2, federal tax return, four recent pay stubs, and proof of any other income, including but not limited to: unemployment, disability, Social Security, and pension benefits or undeclared income) • Asset test (money in bank, cash value of CD's, IRA's etc.) will be considered in the calculation. Please provide bank statements for last two months for both checking and savings accounts. • Approval of application covers services from 6 months to 1 year	Size of Family Unit / As of 01/23/09 At 250% 1: 27,075 2: 36,425 3: 45,775 4: 55,125 5: 64,475 6: 73,825 7: 83,175 8: 92,525
PLAN 2: HSR UNINSURED DISCOUNT PROGRAM (61%) As of 10/01/03, patients whose income levels are at or less than 250% of federal poverty guidelines are eligible for discounts to cost. Effective 9/01/2004, HSR increased the income levels to 350% of the poverty level to qualify. Discount from published charges to cost results in a 61% discount. The discount will apply to patient's exhausted benefits. THIS PROGRAM IS FOR UNINSURED PATIENTS ONLY OR FOR MEDICALLY NECESSARY SERVICES NOT COVERED BY INSURANCE.	To qualify for discount , the following process must be followed: • Completion of FAP application. **Must provide proof of income** (W-2, federal tax return, four recent pay stubs, and proof of any other income, including but not limited to: unemployment, disability, Social Security, and pension benefits or undeclared income) • Approval of application covers services for 6 months • Applicant is not required to apply for general assistance, Medicaid, or Husky programs.	As of Size of Family 01/23/09 Unit / At 350% 1: 37,905 2: 50,995 3: 64,085 4: 77,175 5: 90,265 6: 103,355 7: 116,445 8: 129,535
PLAN 3: HSR UNINSURED DISCOUNT PROGRAM (30%) Income levels over 350% and less than or equal to 500% of Federal Poverty Guidelines are eligible for discounts of 30% off billed charges.	To qualify for discount , the following process must be followed: • Completion of FAP application • Applicant is not required to apply for general assistance, Medicaid, or Husky programs. • **Must provide proof of income** (W-2, federal tax return, four recent pay stubs, and proof of any other income, including but not limited to: unemployment, disability, Social Security, and pension benefits or undeclared income) • Approval of application covers services for 6 months	Size of Family Unit / As of 01/23/09 Over 350% to 500% 1: 37,906 - 54,150 2: 50,996 - 72,850 3: 64,086 - 91,550 4: 77,176 - 110,250 5: 90,266 - 128,950 6: 103,356 - 147,650 7: 116,446 - 166,350 8: 129,536 - 185,050
PLAN 4: CATASTROPHIC CARE DISCOUNT If Hospital charges exceed 20% of family income The discount will also apply to patient co-pays, co-insurance and exhausted benefits. Discount of published charges to hospital cost (61% discount)	To qualify for discount , the following process must be followed: • Completion of FAP application • **Must provide proof of income** (W-2, federal tax return, four recent pay stubs, and proof of any other income, including but not limited to: unemployment, disability, Social Security, and pension benefits or undeclared income) • Asset test (money in bank, cash value of CD's, IRA's, etc.) will be considered. Please provide bank statements for last two months for both checking and savings accounts.	

revised January 23rd, 2009

Administrative Policy: FREE BED FUNDS 4.7

Effective Date: 3/2000

Revision Dates: 3/2007

Review Dates: 3/2007, 3/2008, 3/2009

I. SCOPE

-This policy applies to the Hospital of Saint Raphael.

II. EXCLUSIONS FROM SCOPE

-None

III. POLICY AUTHOR

-Patient Accounting Department

IV. PURPOSE

- To ensure that Bed Funds are made available to all patients meeting the eligibility criteria.

V. POLICY

- The Bed Funds will be administered in accordance with the criteria defined by donor intent.

VI. PROCEDURE

- The procedures to be followed related to administering Bed Funds is as follows:

Bed Fund notice is to be placed in Admitting, Emergency Room, Clinics, Radiology and the Billing Office.

Identified self-pay patients are to be given the Bed Fund Listing and Bed Fund application during the registration process. Information on Hospital Financial Assistance and discount programs is also to be provided. Bed Fund applications are to be given to all patients upon request.

Applications for Bed Funds are to be forwarded to the Billing Office for processing.

Billing office must place a bill hold on account until determination is made on bed fund approval/denial.

Account balances are to be monitored by the billing department for each fund to determine available balances.

Patients are to be notified in writing for both approval and denial.

All self-pay bills are to include information on Bed Fund availability and Financial Assistance programs with contact telephone number. A separate statement ("Are You Uninsured") will also be sent along with Hospital bills.

Applications for bed fund requested by patients over the phone are to be entered as a note to the Patient Accounting System. The application is than forwarded to patient, placing appropriate bill hold notes in system.

Specific Bed Fund eligibility criteria to comply with donor intent is as follows for each fund:

Stiles Fund: Patients in need must apply at the Rectory of St. John's Church of North Haven. Upon notification from the St. John's Episcopal Church) on a pending application a bill hold will be placed. If an approval is given the amount of the award is to be posted to patient account.

Christ Church Fund: Patients in need must apply at the Christ Church of New Haven. Upon notification from the Christ Church on a pending application a bill hold will be placed. If an approval is given the amount of the award is to be posted to patient account.

Alice Derby Lang: Applications to be processed through the billing department. Awards granted based on need and fund availability.

Nurses Alumnae Fund: Applications to be processed through the billing department. Patient must be a graduate of the Hospital of Saint Raphael School of Nursing and a member of the alumnae in good standing.

Edward Malley Fund: Applications to be processed by the billing department. Patient must be an employee of the Edward Malley company, no longer in business.

German Society Fund: Applications to be processed by the billing department. Patient must be of German descent.

Mary Dugan Daly Fund: Applications to be processed by the billing department. Patient must be a descendent of Mary Dugan Daley.

F. Newman & Sons Fund: Applications to be processed by the billing department. Patient must be unable to pay for hospital expenses.

Albert Williams Fund: Applications to be processed by the billing department. Patients must be worthy and deserving patients.

Margaret Hall Fund: Applications to be processed by the billing department. Patients must be a cancer patient residing in New Haven or West Haven.

VII. OTHER INFORMATION

- Applicable Forms and Instructions: Bed Fund Application.

VIII. ATTACHMENTS

-None

IX. REFERENCES

-None

Hospital of Saint Raphael
Administrative Policies and Procedures

Submitted 1/15/2010

Administrative Policy: Accounts Receivable Write-Offs 4.9

Effective Date: 3/2000

Revision Dates: 3/2007, 3/2008, 3/2009

Review Dates: 3/2007, 3/2008, 3/2009

I. **SCOPE:** This policy applies to all SRHS entities with patient accounts receivable.

II. **EXCLUSIONS FROM SCOPE:** None

III. **POLICY AUTHOR:** Patient Accounting Department

IV. **PURPOSE:** To ensure consistent application of accounting treatment for the classification and write-off of accounts as bad debts, provider liable, charity care, risk management, or hospital-policy.

V. **POLICY:** The classification and write-off of patient accounts receivable will be conducted in a manner consistent with sound business practices and in accordance with generally accepted accounting principles.

VI. **PROCEDURE:**

Unless otherwise indicated, write-offs will be charged to the allowance for doubtful accounts. The procedures to be followed related to classification and write-off of patient accounts are as follows:

Bad Debts:

Before a patient account can be considered for write-off as a bad debt by the Billing Supervisor, the following sequence must take place:

- Four (4) statements are sent thirty (30) days apart after the last bill is dropped.
- Follow-up phone calls may be made on account balances in excess of $2,500, depending on documented circumstances regarding the account.
- Three (3) dunning letters are forwarded to patients or guarantors with account balances in excess of $20. Three (3) self-pay letters are forwarded in lieu of dunning letters depending on account balance. Dunning letters may be internally-generated or produced by a contracted vendor, based on SRHS instructions and protocols.
- The account is then reviewed again by the Billing Supervisor, and if full payment or arrangements have not been successful, the account balance is turned over to a collection

agency and written off as bad debt, but not less than one hundred twenty (120) days from date of first billing.

For approval of an account write-off as a bad debt, the account history in the patient billing system must show evidence of the above sequence, or if any departure from the sequence, the reason(s) for same, and must bear approvals of the amount to be written off as follows:

- Up to $20: system-generated and written off directly to "hospital policy", no approval required;
- $20 to $999.99: customer service staff & billers, no approval required
- $1,000 to $4,999.99: approval by the Billing Supervisor;
- $5,000+: approval by the Billing Supervisor and the Administrator, Revenue Cycle;

With appropriate approvals, the Billing Supervisor will process the bad debt write-off. For those in excess of $5,000, the approval of the Administrator, Revenue Cycle will be evidenced within the patient billing system.

Provider Liable:

For a patient account to be considered for write-off as provider liable by the Billing Supervisor, one or more of the following conditions must have been evidenced by a denial of payment of an insurer:

- Lack of medical necessity
- Non-covered services
- No prior authorization or eligibility
- Untimely filing of claims
- Disallowed costs and/or procedures
- Payer contract or program exceptions

Although denial of payment is a consideration, any of the conditions precedent to denial must have been appealed where a basis of appeal exists, and all appeals must be exhausted prior to submission for write-off as provider liable. Such appeals include, but are not limited to billing process review, medical review, payer contract review, and program participation review by appropriate billing, medical, financial planning, and contracting staff.

In cases where it has been determined that rendering a claim for patient services may not be appropriate due to documentation issues, CMS compliance issues, or other valid reasons as noted, a denial of payment by an insurer is not applicable as a condition for write off.

For approval of an account write-off as provider liable, the provider liable write-off authorization must show evidence that the condition(s) precedent exist, that appeals have been exhausted, or if any other condition for write-off exists, the reason(s) for same, and must bear approvals of the amount to be written off (at the estimated net reimbursement or net contracted rate amount) as follows:

- up to $999.99: customer service staff & billers, no approval required
- $1,000 to $4,999.99: approval by the Billing Supervisor;
- $5,000+: approval by the Billing Supervisor and the Administrator, Revenue Cycle;

With appropriate approvals, the Billing Supervisor will process the charity care write-off. For those in excess of $5,000, the approval of the Administrator, Revenue Cycle will be evidenced within the patient billing system.

Charity Care:

The System's mission and statement of values includes dignity, charity, justice and stewardship for all persons in need of our services, regardless of their ability to pay. The Saint Raphael Healthcare System follows the Emergency Medical Treatment and Active Labor Act ("EMTALA") in providing emergency medical treatment at the Hospital of Saint Raphael. As such, the Hospital will treat any patient in an emergency condition, whether or not covered by insurance, and regardless of the patient's ability to pay.

For a patient account to be considered for write-off as charity care by the Billing Supervisor, there must be evidence that the patient has applied for and exhausted financial assistance and/or bed fund assistance and a determination has been made by the patient account representatives (financial counselors and collectors) that the patient has a documented inability to render payment.

For approval of an account write-off as charity care, the charity care write-off authorization must show evidence that there is a documented inability to pay, or if other condition for write-off exists, the reason(s) for same, and must bear approvals of the amount to be written off as follows:

- up to $999.99: customer service staff & billers, no approval required
- $1,000 to $4,999.99: approval by the Billing Supervisor;
- $5,000+: approval by the Billing Supervisor and the Administrator, Revenue Cycle;
-

With appropriate approvals, the Billing Supervisor will process the charity care write-off. For those in excess of $5,000, the approval of the Administrator, Revenue Cycle will be evidenced within the patient billing system

Risk Management:

Accounts may be periodically written off as part of the monitoring of malpractice and risk management matters related to the SRHS's self-insurance program. The procedures to be followed related to Risk Management Write-offs are as follows:

· The Risk Management department will determine, based upon the facts and circumstances of a particular incident, whether the (1) holding of an account to determine whether a billing will ultimately be made or (2) the patient bill will be adjusted to a lower value is justified in accordance with Risk Management policies and procedures.
· Upon request from the Risk Management department, Patient Accounting will identify the amount of the outstanding account balance for the case under consideration, as well as whether any insurance payment is pending.
· Upon receipt of the account balance information from Patient Accounting, and after consideration of the facts and circumstances of a particular incident, Risk Management will instruct Patient Accounting to either bill the account, partially bill the account, or record the entire account balance off as a write-off. Such write-offs will not be charged to the allowance for doubtful accounts, but rather to a directed expense account within a cost center as designated by the Manager of Accounting.
Patient Accounting will respond to all requests for account information received from Risk Management utilizing the "Risk Management Account Review" form. The Patient Billing representative preparing the form will sign and date the form prior to forwarding to Risk Management for follow-up. No further account collection activity is authorized to occur until the form is returned to Patient Billing. The action(s) to be taken relative to a particular account must be authorized in writing by Risk Management department representatives on the form. A written record of the authorized action to be taken on an account, including the authorizing Risk Management representative, must be documented in the memorandum portion of the patient billing system.

Hospital-policy:
Accounts may be written off when it is deemed in the best interests of hospital policy to do so. The procedures to be followed related to "hospital policy" write-offs are as follows:
· At the level of Vice President or above ("the executive") it will be determined with that individual's discretion and judgment, based upon the facts and circumstances of a particular case, whether (1) holding of an account to determine whether a billing will ultimately be made or (2) the patient bill will be adjusted to a lower value.
· Upon request from the executive, Patient Accounting will identify the amount of the outstanding account balance for the case under consideration, as well as whether any insurance payment is pending.
· Upon receipt of the account balance information from Patient Accounting, and after consideration of the facts and circumstances of a particular case, the executive will instruct Patient Accounting to either bill the account, partially bill the account, or record the entire account balance off as a write-off. Patient Accounting will then note in the memo section of the billing system, the executive who directed the write-off.

· Because many of the circumstances leading to use of the manager's discretion and judgment may require a high level of confidentiality, any supporting documentation may be kept with the manager and so noted.

VII. OTHER INFORMATION

VIII. ATTACHMENTS

IX. REFERENCES

Administrative Policy: COLLECTION AGENCY FOLLOW UP 4.12

Effective Date: 3/2000

Revision Dates: 3/2007, 3/2008, 3/2009

Review Dates: 3/2007, 3/2008, 3/2009

I. SCOPE

- This policy applies to all SRHS entities with patient accounts receivable

II. EXCLUSIONS FROM SCOPE

-None

III. POLICY AUTHOR

-Patient Accounting Department

IV. PURPOSE

- To provide patient representatives (financial counselors and patient account collectors) and contracted collection agencies with guidelines in the collection of patient accounts receivable and billing inquiries.

V. POLICY

- Collection activities on patient accounts will be conducted in accordance with established guidelines that secure the optimum prospect for realization of such accounts.

VI. PROCEDURE

-: The procedures to be followed related to collection activities directly with patients is as follows:

A financial counselor will initiate the process by meeting with the patient at the time of admission and/or while the patient is still in the hospital to determine if an account may potentially require collection assistance based on the financial data compiled. In those instances where the financial counselor recognizes a need for a Patient Accounts Representative's involvement with an account, the findings are noted in MEDIPAC system and forwarded to a Patient Accounts Representative. The financial counselors in the Admitting/Patient Registration Department will autokey the account to the patient accounts staff on a daily basis. The patient accounts representative will note in the MEDIPAC systen, whether the policies related to "Bed

Funds" (policy 4.7), "Protection for Uninsured Patients" (policy 4.20), and "Guidelines for Financial Assistance" (policy 4.6) apply.

At the time an account appears on a patient accounts representative's work list, the representative is to begin attempts to contact the patient at home or at their place of employment for follow-up on applications that may have been filed for assistance or to plan and verify other payment arrangements. Representatives should not attempt to contact a patient by phone before 8:00 a.m. or after 8:00 p.m.. (Demographic information is located in Medipac on the Patient Alpha Update screen). In addition to the primary responsibility of collection attempts, the representative is also responsible for updating account data for insurance, demographic, financial assistance, bed fund status and payment arrangements.

If no contact is made, the representative will send a series of approved collection letters. The collector will make the decision, based on historical data, whether to allow more time for follow up or to recommend to supervisor to turn over the account to a collection agency.

No patient account can be turned over to a collection agency if all of the following is applicable and the Accounts Receivable department has been provided with a Financial Assistance Application:

· The patient's income is at or below 250% of poverty income guidelines.

· The patient has applied for, and been denied, eligibility under the general assistance or Medicaid programs.

· Patient is not eligible for coverage under any private or government sponsored health or accident insurance or benefit program.

Each inpatient account that appears must be reviewed by the representative to ensure there are no recent payments or activity since the final dunning letter mailing.

Outpatient accounts do not require authorization for turnover to a collection agency. However, the following exceptions apply:

· Account balance is greater than $2,500.

· Outpatient Medicare accounts to be turned over to a collection agency are to be reviewed by the supervisor of Self-Pay Billing for review prior to being placed with an agency.

· The patient accounts department staff must review all self-pay accounts for Medicaid eligibility.

The Billing Supervisor will analyze, assign, and place uncollectible accounts to the respective collection agencies that represent the hospital. Agencies utilized for collection must acknowledge accounts within five (5) days of receiving the name, balance turned over, and account number.

The agency is required to refer any inquiries to the customer service representatives.

The agency is to submit payment reports monthly, no later than the 15th of the month. The payment report will show the following:

- Patient name
- Account number
- Total payment
- Agency fee
- Net payment
- Remaining balance
- Inpatient total
- Outpatient total (by patient type)

- Direct payments reported from the Hospital (these are payments received by the Hospital for an account being held by the collection agency). These payments are recorded on a separate payment list and forwarded to the collection agency on a monthly basis in order for the agency to receive the credit for the collection.

All accounts turned over to a collection agency will appear on a monthly report (the "KP920BC" report). This monthly report, which is called the Collection Agency Information Report, lists all accounts that have been placed with a collection agency and will be sorted by agency for distribution .All account reversals will not be distributed to agencies. An account reversal is any account that has already been prepared for turnover but no longer requires collection agency assistance.

An account may be recalled from a collection agency by informing the Collection Agency Clerk of the reason, who will in turn notify the agency, complete reversal, and disburse to the patient account representative who has requested the account recalled.

The agency will return accounts that are deemed not collectable at anytime.

Accounts requiring legal action should be verified by a collector with financial data on file (as updated, when possible) to ensure that the guarantor has available assets and/or is employed. Outpatient accounts requiring legal action are given to the collectors to review before placement with a collection attorney. The decision to send to a collection attorney ultimately rests with the collection agency, with approval for legal action required to be obtained from the Administrator, Revenue Cycle.

VII. OTHER INFORMATION

-None

VIII. ATTACHMENTS

-None

IX. REFERENCES

-None

Administrative Policy: PROTECTION FOR UNINSURED PATIENTS 4.20

Effective Date: 3/2000

Revision Dates: 3/2008

Review Dates: 3/2007, 3/2008, 3/2009

I. SCOPE

- This policy applies to the Hospital of Saint Raphael.

II. EXCLUSIONS FROM SCOPE

-None

III. POLICY AUTHOR

-Patient Accounting Department

IV. PURPOSE

- To define criteria for protection of uninsured patients.

V. POLICY

-Patients who are uninsured and meet certain guidelines may be eligible for free care or discounted payment terms and will be protected from specific collection practices as follows:

- Patients who are uninsured, below 250% of the federal poverty level (FPL) and meet certain other financial guidelines may be eligible for discounted care up to 100% of billed charges.
- Discounted payment will be accepted from patients who are uninsured and who are at or below 350% of the federal poverty level (FPL), in an amount not to exceed hospital cost.
- Discounted payment will be accepted from patients who are uninsured and whose hospital bills exceed 20% of patient's annual income, in an amount not to exceed hospital cost.
- Discounted payment will be accepted from patients who are uninsured and who are between 350% - 500% of the federal poverty level 70% of hospital charges.

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VI. PROCEDURE

- The procedures to be followed related to protecting uninsured patients from certain collection practices are as follows:

A Financial Assistance Plan ("FAP") application and/or Bed Funds application must be completed by the patient or the qualifying family member. The Hospital will accept a FAP for co-payments, co-insurance or other amounts due as a result of exhausted benefits. The insured must also apply for city/state assistance and present denial. A determination as to which criteria apply as defined above will be made.

Wage garnishments or liens on homes or other assets will not be used to collect unpaid bills from qualifying families.

Unpaid bills will not be sent to outside collection agencies as long as the patient is cooperating in efforts to settle the bill.

Extended payment plans offered by the Hospital in settling the payments of such patients will be interest free.

VII. OTHER INFORMATION

-None

VIII. ATTACHMENTS

-None

IX. REFERENCES

-None