[redacted] Memorial Hospital
Administrative Policy

TITLE: Accounts Receivable Billing and Collections

PURPOSE: The following policy and procedure is to be followed for billing and collecting of patient accounts. The purpose of the procedure is to establish a system whereby we will have constant knowledge of each account. It will provide a step by step procedure that will maintain constant contact with the responsible party for discharge through complete payment of the account, write-off, or charge-off.

DEFINITIONS:

Bad Debts: Bad debts are claims arising from rendering healthcare services to a patient that the hospital, using sound credit and collection policy, determined to be uncollectible from patients who have the ability to pay.

Contractual Allowances/Discounts: Contractual allowances/discounts are the excess of the hospital's normal charge for healthcare services over the payment received from third party payors under contractual agreements.

Policy Discounts: Differences between revenue recorded at established rates and amounts realizable for services provided to employees (i.e. day care).

Community Free Care: Community free care are charges for healthcare services that are written off based on the hospital community free care policy. A claim can be considered community free care after an investigation of the patient's ability to pay, including non-qualification for a government program. Community free care does not include any of the following: Medicare Bad Debts, Contractual Allowances/Discounts, Policy Discounts.

PROCEDURE:

A. Billing

1. In order to maintain familiarity and understanding of the patient's account, each Business Associate is assigned a section of the alphabet. The Business Associate follows the patient from admission, for inpatients, or initial billing through the final settlement of the account.

2. Itemized Bills: Sent to insurance, worker's compensation, and private pay patients, upon request.

   a. If the patient has insurance coverage, the designated Business Associate will submit each claim to the patient's insurance company, either by electronic submission or by mail.

   b. If the patient is classified Private Pay, a first time summary bill will be mailed to the patient or their guarantor within 30-40 days after discharge of an outpatient/emergency room visit. The first time bill states their responsibility. An itemized bill is sent upon request.

3. Monthly Statement: Sent on a cycle basis. This procedure is repeated approximately every thirty (30) days until the account is paid, considered uncollectible, sent to early out, or written off.

B. Collection

1. Prior to Discharge: Every admission to the hospital must have the responsible party sign a Statement of Financial Responsibility.

2. Upon Inpatient or Discharge of Outpatient: Attempt to collect [redacted] MA co-pays. If the patient has insurance, collect the amount estimated that will not be paid by the insurance. In outpatient charges, attempt to collect [redacted] MA co-pays, hearing aids, batteries, and any other over-the-counter items owed, regardless of the situation. It is better to over-collect and refund than to be left with an uncollectible account.

3. After Discharge or Outpatient Charges: Follow the billing procedure first with the patient bills, then with the monthly statements as follows:

   a. Patient accounts with no insurance coverage – After following the billing procedure with accounts where there was no payment or other action, each step is noted by the Business Associate starting here:

      (1) 1st Monthly Statement – Approximately 30 days – send statement.

      (2) 2nd Monthly Statement – Approximately 60 days – send statement with appropriate message.

      (3) 3rd Monthly Statement – Approximately 90 days – send statement with appropriate message.

      (4) Account is sent to Early Out program.

      (5) The Early Out program will work the account for 30 days. If Early Out is unsuccessful in setting up an acceptable payment plan, the account will be presented back to the hospital for approval of collection write-off.

      (6) Accounts are listed for Collection Write-Off – The report lists the patient's account number, name, date of write-off, and amount of write-off.

      (7) The report is presented to the Chief Executive Officer, Chief Financial Officer, and Board of Directors for approval at the next Board meeting.

   b. Patient accounts with insurance coverage if insurance pays and there is a balance due:

      (1) 1st Monthly Statement shows the total amount of the bill, how much the insurance paid, and the balance due from the patient.

      (2) 2nd Monthly Statement (if there is no payment received) is sent out with balance due. All action taken from this point on is noted by the Business Associate.

      (3) 3rd Monthly Statement (if there is no payment received) is sent out with balance due.

      (4) Account is sent to Early Out program.

(5) The Early Out program will work the account for 30 days. If Early Out is unsuccessful in setting up an acceptable payment plan, the account will be presented back to the hospital for approval of collection write-off.

(6) Accounts are listed for Collection Write-Off – The report lists the patient's account number, name, date of write-off, and amount of write-off.

(7) The report is presented to the Chief Executive Officer, Chief Financial Officer, and Board of Directors for approval at the next Board meeting.

c. Patient accounts with insurance coverage if insurance does not pay and/or sends a rejection notice:

(1) 1st Monthly Statement – Make note that insurance has either denied the bill or has not responded to the claim. If the latter occurs, follow up with insurance company by telephone to check on status of claim. Send monthly statement to patient with note that we have not heard from their insurance company – please contact them.

(2) 2nd Monthly Statement – If there has been no payment or other action on the account, all action taken from this point on is noted by the Business Associate. Follow Collection Procedure for patient accounts with no insurance coverage starting with 2nd Monthly Statement.

4. On an ongoing basis, Business Associates will monitor patients who consistently do not pay their bills and yet are regularly visiting the hospital. The Business Associates will keep the Business Office Manager apprised of problem situations. The Business Office Manager will be responsible for informing appropriate persons.

C. Financial Arrangements – Credit Policy

1. Financial Arrangements – Following is a guide for establishment of a payment schedule for accounts.

Amount Owed	Payment Expected
$0 - $100	$10 per month
$100 - $200	$25 per month
$200 - $500	$50 per month
$500 - $1000	$100 per month
$1000 or greater	10% of balance or to be paid in full within 24-months

If patient fails to follow through on their monthly payment agreement: each step taken is noted by the Business Associate.

a. 1st Monthly Statement – Business Associate will remind the patient that regular monthly payments are necessary.

b. If no payment is received, account is sent to Early Out program.

2. General Credit Policy – Try to get the responsible party to agree to a specific payment plan. If patient states no payment can be made at this time, allow one (1) to three (3) months grace, depending on the situation. Patient must contact us at that time to inform us of the status.

3. Community Free Care – A patient can apply for community free care. See Criteria and Plan of Action for Patient Unable to Pay policy.

D. Write-Off Procedure – Accounts reviewed by the Business Associate, Patient Accounts Manager, Business Office Manager, or Chief Executive Officer that are deemed uncollectible are reported as follows; reviewed by the Chief Financial Officer and Business Office Manager; and then presented to the Board of Directors for approval every month.

1. Accounts to be written off to the Collection Agency, Complete and Final Write-Offs (Plain), Bankruptcy, and Community Free Care Write-Offs are listed separately.

2. The report lists the patient's account number, name, date of write-off, and amount to be written off, as well as the type of write-off.

3. The Patient Accounts Manager shall note on each patient billing the amount written off, date of write-off, and type of write-off.

4. These written-off accounts will be segregated in files listed under "Free Care", "Plain" (Complete), and "Collection" Write-Offs.

E. Other Items

1. Record insurance rejections, effective dates of bankruptcy, and patient agreements to pay in the computer under the patient's account. Each entry is dated and initialed by the individual concerned with the action taken.

2. Check accounts in computer by Guarantor including Collection Write-Offs before signing a receipt "Paid in Full" or accepting a check marked "Paid in Full".

3. The Hospital will make a reasonable attempt to collect deductibles and copayments from all patients.

4. Business Associates will track claim denials on a report and submit monthly to the Financial Services Associate. Denials will be sorted by reason, biller, and department. Supporting documentation will be given to the Business Office Manager. The Patient Accounts Manager and/or Business Office Manager will review accounts prior to write-off. The Financial Services Associate will email a report to Department Heads.

Note: Any special deviations from this procedure should be brought to the attention of the Patients Account Manager, Business Office Manager, Chief Financial Officer, or Chief Executive Officer.

[redacted] Memorial Hospital
Administrative Policy

TITLE: Community Free Care

PURPOSE: To establish guidelines and procedures to determine patient eligibility for the purpose of granting community free care to patients unable to pay.

A. POLICY

1. [redacted] Memorial Hospital will not exclude any person from receiving health care services because of their race, color, sex, creed, national origin, sexual orientation, handicap, or age. No patient, regardless of ability to pay, will be denied treatment for emergency services for conditions that are life threatening or could result in serious bodily harm.

2. The annual amount of community free care will be determined by the financial status and budget of the hospital and approved by the Chief Executive Officer and Board of Directors.

3. The calculation of the amount generally billed to individuals who qualify for financial assistance will be based on the average of the three best negotiated commercial rates. [redacted] Memorial Hospital will allow a five percent reduction of gross charges prior to calculating the percentage of eligible write-off to individuals who qualify under the Community Charity Care Policy.

Example: Gross patient charges	$100.00
Less 5% (average of 3 best negotiated commercial rates)	-5.00
Amount used for application of eligible Charity Care Discount	$ 95.00

4. Community free care may be available for emergency and elective services applicable to inpatient, outpatient, skilled, home health, and hospice care.

5. Charity care financing may be provided to those patients having no insurance coverage or inadequate third party insurance coverage at the time of admission or upon receipt of a retroactive denial.

6. Accounts previously written off to bad debts but subsequently returned as uncollectible by the Hospital collection agency will be considered charity care because the professional agency has determined the patient is unable to pay the bill.

7. If a person with an outstanding hospital bill declares bankruptcy or is deceased with no estate, the account will be classified as charity care.

8. Patients applying for charity care must exhaust all government assistance programs first, such as Medical Assistance, [redacted], and General Relief.

B. Patient Eligibility Criteria – The following criteria will be used to identify persons who are unable to pay for needed health care services.

1. Confirmation that the patient is not covered or receives services that are not covered by a third party insurer or government program.

2. The patient, financially, is not able to pay for the services or, under special circumstances, approved by the Chief Executive Officer.

C. Patient Financial Eligibility Criteria – The following financial criteria will be utilized for identifying persons unable to pay for needed services.

1. The financial criteria established by current federal poverty guidelines will be followed and will apply to all types of care.

2. Individual net worth will also be a factor in determining eligibility.

3. Circumstances may dictate that the above criteria be waived; however, all community free care must have approval of the Business Office Manager, Chief Financial Officer, or Chief Executive Officer as set forth in section D.7.

4. It is the responsibility of the applicant to provide the hospital with the necessary information in order that we may determine eligibility.

5. Applicant may be required to complete and sign a community free care application. The hospital may request to view the applicant's recent W-2, federal and state income tax return, or other proof of income or assets in order to make a financial determination.

D. Community Free Care Administrative Procedure

1. The financial status of the patient applying for community free care will be established as soon as possible after receiving the application and all requested information.

2. The patient, physician, family member, hospital staff, or others can request community free care for a patient.

3. Application for community free care for elective services should be made in advance of receiving the elective services. The patient should contact the hospital's business office to provide the necessary information.

4. The patient will be notified when their application for community free care has been accepted or denied.

5. Medicare, Medicaid, and other third party contracts will not be considered as community free care.

6. There are no time limits or other restrictions on declaring an account or patient as free care. This includes time elapsed, collection status, type of care, or whether it is a deductible or the unpaid portion of a third party payment.

7. Accounts greater than $2500 will have the approval of the Business Office Manager, Chief Financial Officer, and Chief Executive Officer. Accounts ranging from $1000 - $2500 will be approved by the Business Officer Manager and the Chief Financial Officer. Accounts less than $1000 will be approved by the Business Office Manager, with the exception of items listed in A.6.