Phelps County Regional Medical Center	Title: **A R Management**	Reference Word: **A R**
	Initiated: **01/99**	Revised: **01/08; 05/11; 04/14; 04/16; 01/18**
	Manual: **Patient Financial Services**	Page 1 of 7

Purpose: To provide guidelines for managing patient accounts to minimize the number of accounts that result in Bad Debt or Financial Assistance write offs.

Policy: It is the policy of PCRMC to treat all patients without regards to race, religion, national origin or ability to pay. By maintaining an aggressive financial services program the hospital can minimize its bad debt expense due to early identification and actions taken with uncollectible accounts.

Definition:

Patient Accounts: Money claims against patient and third party payers for medical services rendered.

Bad Debt: Charges written off for individuals who refuse to pay or meet financial assistance guidelines.

Financial Assistance: Charges approved thru an application process to be written off for individuals lacking the means and ability to pay.

Correspondence: Informational, demand, pre-collect, collection letters and monthly statements.

Procedure:

A. **ELECTIVE PROCEDURES**

PCRMC requires proof of financial clearance from all patients prior to receipt of elective services. Financial clearances are defined as reasonable adequate proof that the patient's bill will be paid by the guarantor or third party. The patient or guarantor can demonstrate financial clearance in any of the following ways:

1. Payment of the required 25% deposit on or prior to procedure.
2. Proof of insurance coverage and their obligation to pay for the procedure.

B. **HOSPITAL BASED PHYSICIAN OFFICE VISITS**

Any office visit co-pay is due at the time of service, unless prior arrangements have been made with the Hospital Patient Financial Services Department.

C. **PRESUMPTIVE FINANCIAL ASSISTANCE ELIBIBILITY**

PCRMC understands that certain patients may be unable to complete a financial assistance application, comply with requests for documentation, or are otherwise non-responsive to the application process. As a result, there may be circumstances under which a patient's qualification for financial assistance is established without completing the formal assistance application. Under these circumstances, PCRMC may utilize other sources of information to make an individual assessment of financial need. This information will enable PCRMC to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

PCRMC may utilize a third-party source or websites such as Missouri Case Net to determine if a deceased patient has an Estate in Probate Court. PCRMC may also utilize other sources such as charitable/governmental organizations to determine socio-economic and financial needs of the patient. This information may be used to determine presumptive eligibility for a patient that may not be able to complete or provide adequate documentation of financial need under this policy.

Patient accounts granted 100% presumptive eligibility will be reclassified under the financial assistance policy. They will not be sent to collection, will not be subject to further collection actions, will not be notified of their qualification and will not be included in the hospital's bad debt expense.

No refunds will be made on payments applied to insurance co-pays and/or deductibles.

D. **SELF PAY**

A discount of 30% off gross charges is given to all self-pay patients that do not meet Financial Assistance requirements. Self-pay patients that meet the Financial Assistance requirements will not receive both discounts if they are below 225% of the poverty guidelines.

The Hospital (Agent) will attempt to contact all self-pay patients (guarantors) both inpatient and outpatient who are personally responsible for their entire bill.

1. Screen the patient to see if they might be eligible for Medicaid or some other governmental assistance programs.

2. If the patient does not appear to qualify for any programs a Financial Assistance application should be given to the patient (guarantor).

Collection Team Members review each patient account that has a self-pay balance to verify that a balance due letter has been sent to the patient. Team Members will make reasonable efforts to orally communicate that the organization has a financial assistance policy and explain how to complete the financial assistance application.

1. Letter will be mailed notifying the patient of the amount of their bill will be sent. This letter offers the patient an additional 10% prompt pay discount if paid in full with 14 days. This prompt pay discount does not apply to any deductible and co-pay amounts after insurance has paid. This letter also notifies the patient/guarantor that financial assistance is available and provides different means to access the application. A reminder is set for 45 days.
2. If no payment after 45 days, then call the patient if the account balance(s) are $5,000.00 or over to ask for payment in full or work with the patient on agreeable payments (including interest free bank loan financing). If no answer, send a financial application if the patient is a Missouri resident who is a United States Citizen or married to a US citizen and live in our eleven (11) county service area. College student's residency will be determined by the tax forms of the person who claimed them as an exemption on the most recent completed tax year.
3. If no payment or financial application after 30 days and the account(s) are $5,000.00 or over, attempt one more call to patient. If no answer or return call, then send letter that the account may be sent to a collection agency.
4. The account balance amount, timing/duration and activity may be adjusted upon approval of the PFS Director or Designee. Factors such as staffing levels and current workload indicators will be considered when making these adjustments.

E. **THIRD PARTY (Insurance)**

PAR's will work their queues as follows:

1. Review each account to see if all insurance has paid. If paid, an insurance paid letter will be sent to notify the patient. This letter notifies the patient that their insurance has paid, the balance due is their responsibility and requests payment in 15 days. This letter also notifies the patient/guarantor

that financial assistance is available and provide different means to access application. The reminder is set for 45 days.

2. If no payment after 45 days and the account is $5,000.00 or over, then attempt to call and ask for payment in full or agreed upon payments (including bank loan financing or financial assistance). If no answer or contact, then send a past due letter and set the reminder for 15 days.
3. If no payment or contact after 15 days, then send to a collection agency.
4. If the patient has a current payment plan, a new account can be attached to their existing payment plan if they agree to increase their monthly payment and pay within 6 months. Patients needing a longer payment plan will be offered interest free bank loan financing. The patient will be obligated to meet the terms of the bank loan agreement. Patients not able to meet the terms of bank loan financing and are unable to increase their payments may be asked to furnish justification by filling out a financial application and furnishing all documentation required. Patients who default on either the internal payment plan or the bank loan financing may be forwarded to a collection agency.

An exception to the above procedures(s) would be if a patient has previous accounts at a collection agency. The number of accounts and the length of time at the collection agency are reviewed at this time.

At any time during the collection process, a piece of correspondence is returned to the hospital as undeliverable: it will be reviewed for the correct address. A telephone call will be made to locate and update the address. If the telephone number is out of service or the patient does not return the call with an updated address, the account may be sent to a collection agency.

If the patient can't be reached by telephone and we have a good address, a financial application attached to a letter of explanation and a self-addressed envelope is mailed to the patient if they are a Missouri resident who is a US citizen or married to a US citizen and reside in our primary service area of the following counties: Phelps, Dent, Texas, Pulaski, Maries, Crawford, Osage, Gasconade, Laclede, Camden and Miller. College student's residency will be determined by the tax forms of the person who claimed them as an exemption on the most recent completed tax year.

After the initial letter and two statements have been sent out and no payment has been received, a past due letter will be sent out to remind the patient that

their account is due and may be sent to the outside collection agency if they do not pay the balance, contact the hospital to set up payment arrangements or request a financial assistance application.

The hospital will make reasonable efforts to notify patients in every form of communication (verbally, letters and statements) that financial assistance is available.

Every 30 days the account will go to worklist for review. If the patient is past due with no payment in full, agreed payment arrangement (bank loan financing) or financial assistance application, then a past due notice may be sent to the patient. If the patient has not responded, the account may be turned to the outside collection agency.

Collection activity/action of all patient account balances (whether self-pay or otherwise), PCRMC, collection agencies and third party bill handlers working accounts on behalf of PCRMC, will not include the following **extraordinary collection action as defined by the IRS**: employ debtors prison, selling a patient's debt to a third party, attaching or seizing a patient's bank account or other personal property, foreclosing on a patient's real property, causing a patient to be subject to a writ of body attachment, causing a patient's arrest, or liens on principal residences.

The Collection Agency(s) may report the unpaid debt to the Credit Bureau's (extraordinary collection action) after having the account for 180 days from date of first post-discharge billing statement. If the balance is or may be due from an insurance company or other third party, the collection agency must wait at least 180 days, from date of post-discharge billing statement, before reporting to the credit bureaus.

Legal action (extraordinary collection action), including liens on any appropriately attached assets or exercised through permitted state law garnishments, may be taken by the Collection Agencies after having the account for a minimal period of 120 days from first post-discharge billing statement. Legal action must be approved by the hospital Director of Patient Financial Service or his/her designee before this extraordinary collection action is taken.

Hospital will make reasonable efforts to communicate in each piece of correspondence sent by Patient Financial Services that financial assistance is available. This notification of financial assistance will be made least 30 days prior to any extraordinary collection action. Reasonable efforts will also be made by Patient Financial Services to verbally communicate that financial assistance is available and provide instructions on how and where to obtain a financial assistance application.

F. **BILLING**

1. Billers' alternate weeks downloading claims from Meditech to SSI.
2. Billers' alternate working confirmation reports within their payer group. (Medicare and Commercial every 4 weeks. Medicaid every other week).
3. Billers alternate initiating the note posting and confirmation machine every 10 weeks.
4. Compile and print daily reports, 72 hour and same day service and combine accordingly.
5. Generate electronic remits for secondary billing and work accounts accordingly.
6. Do follow up on work queues (phone calls to insurance companies, check account status on-line, call patients, call physicians, send letter, etc.). Note what was done in the message screen.
7. Empty mail box with correspondence and EOB's and sort. Correspondence and EOB's are to be worked timely. Note accounts.
8. All Medicare billings should be reviewed to make sure that the correct primary payer is being billed.
9. Once daily download is completed, work 1500's and UB's for automated submission to send by 1:00 pm.
10. Print hard copy claims to mail and attach Medical Records if needed, i.e. VA claims. Note in BAR and MRI.
11. CCI edit issues go to Assistant Director for review.
12. Charge issues go to Charge Auditor for review.
13. Coding issues go to Assistant Director for referral to iMedX.
14. Check the iMedX report for any outstanding issues and work promptly.
15. Work the late charge/credit report daily.
16. Biller Queue is to be checked daily for timely issues, missing physician, missing ID number, invalid NPI, etc.
17. Check pending accounts in SSI weekly.

G. **CREDIT BALANCES**

Credit balances are worked daily. Refund requests are prepared or insurance/Medicare is notified to take their money back. All refunds issued or requested by a check will be approved by the Director of Patient Financial Services or Designee.

H. **ITEMIZED STATEMENT REQUESTS**

It is important that copies of itemized statements be sent to individuals who are properly authorized to receive them.

All itemized statements sent out should be stamped with "Insurance Benefits are assigned to the Hospital" or this should be hand written and signed by the person sending out the itemized bill.

I. **HOSPITAL LIEN**

If it is found that an admission/visit is due to an injury resulting from a motor vehicle accident, it may be advisable to file a Hospital Lien.

The Hospital or its agent will be responsible for filing liens.

Recommended by:	Kent D. Johnson Director of Patient Financial Services
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