

**DOWN EAST COMMUNITY HOSPITAL
POLICIES & PROCEDURES**

Policy #9821123

TITLE: Billing and Collections

SECTION: Patient Financial Services	APPROVED BY:	DATE:
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Purpose: The purpose of this Policy is to establish a procedure for collecting patient accounts including those that have become delinquent due to lack of payment from the patient or responsible party.

Policy: Down East Community Hospital (DECH) strives to collect all self-pay patient accounts in a timely manner in order to maximize cash flow. DECH utilizes a series of billing statements, either through the hospital billing system or through Carepayment, as well as the services of collection agencies to accomplish this. It is the policy of DECH to comply with Section 501(r) of the Internal Revenue Code and implementing regulations with respect to DECH’s billing and collection activities.

Definitions:

Financial Assistance Policy (“FAP”): DECH’s Financial Assistance Policy (Policy # 1016), as amended from time to time.

Extraordinary Collection Actions (“ECAs”):

The following actions taken by DECH, or an authorized contractor or agent of DECH, against an individual related to obtaining payment for a bill for care covered under the FAP:

- Selling an individual’s debt to another party;
- Reporting adverse information to a consumer credit reporting agency or credit bureau;
- Deferring or denying, or requiring payment before providing, medically necessary care because of nonpayment of one or more bills for previously provided care under DECH’s FAP;
- Actions that require legal or judicial process, including but not limited to:
 - Placing a lien on property;
 - Foreclosing on real estate;
 - Attaching or seizing a bank account or other property;
 - Commencing a civil action;
 - Causing an arrest;
 - Causing the issuance of a writ of body attachment;

- Garnishment of wages; and
- Other actions that are ECAs under 26 C.F.R. § 1.501(r)-6(b).

The following activities are **not** ECAs:

- Liens DECH would be allowed to assert under state law on the proceeds of a judgment, settlement, or compromise as a result of personal injuries for which DECH provided care; and-
- The filing of any claim in a bankruptcy proceeding.

Amounts Generally Billed (“AGB”): As used in this Policy, AGB shall have the same meaning given this term in the FAP.

Procedure:

I. Collection Activities, Generally: In both the hospital and physician practices, accounts are written off and placed with collection agencies at the end of each month according to billing frequency guidelines and this Policy.

II. Initiating ECAs:

Prior to engaging in any ECA against a patient (or any individual who has accepted or is required to accept responsibility for the patient’s bill) to obtain payment for care, DECH shall take steps to determine whether the individual is FAP-eligible for the care as provided under subsections A or B below.

A. Presumptive FAP-Eligibility Determinations Based on Third-Party Information or Prior FAP-Eligibility Determinations

With respect to any care provided by DECH to an individual, DECH may determine that an individual is FAP-eligible based on information other than that provided by the individual or based on a prior FAP-eligibility determination. If the individual is presumptively determined to be eligible for assistance less than free care under the FAP, DECH shall:

1. Notify the individual regarding the basis for the presumptive FAP-eligibility determination and the way to apply for more generous assistance under the FAP;
2. Give the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care; and
3. If the individual submits a complete FAP application seeking more generous assistance during the reasonable period of time,

determine whether the individual is eligible for a more generous discount and take the steps under Subsection II.B.4.

If the individual fails to apply for more generous assistance within the reasonable period of time, DECH may engage in ECAs.

B. Notification and Processing of a FAP Application

DECH shall make reasonable efforts to notify patients of DECH's FAP and process FAP applications under this Subsection as follows:

1. DECH shall refrain from engaging in any ECA until at least 120 days after DECH provides the first post-discharge billing statement for the care (or multiple episodes of care); and
2. At least 30 days before initiating an ECA to obtain payment for the care, DECH shall:
 - (i) Provide the individual, in a clear and conspicuous manner, with a plain language summary of the FAP and a written notice that (a) indicates financial assistance is available for eligible individuals, (b) identifies the ECAs that DECH (or DECH's representative) intends to initiate to obtain payment for the care, and (c) states a deadline after which such ECAs may be initiated that is no earlier than 30 days after the date that the written notice is provided; and
 - (ii) Make a reasonable effort to orally notify the individual about DECH's FAP and about how the individual can obtain assistance with the FAP application process; and
3. In the case that an individual submits an incomplete FAP application by the application deadline, DECH shall:
 - (i) Notify the individual in writing about how to complete the FAP application and provide a phone number and location of Patient Financial Services; and
 - (ii) Not initiate, or take further action on previously-initiated, ECAs until the individual has failed to respond to requests for additional information and/or documentation within a reasonable period of time, or if the individual completes the FAP application, DECH has determined whether the individual is FAP-eligible; and
4. In the case that an individual submits a complete FAP application by the application deadline, DECH shall:

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- (i) Not initiate, or take further action on previously-initiated, ECAs;
- (ii) Make a determination as to whether the individual is FAP-eligible for the care and notifies the individual in writing of this eligibility determination and the basis for this determination; and
- (iii) If it is determined that the individual is FAP-eligible:
 - (a) If the individual is eligible for assistance other than free care, provide the individual with a billing statement that indicates the amount the individual owes.
 - (b) Refund to the individual any amount paid for the care that exceeds the amount the individual is determined to owe as a FAP-eligible individual, unless such excess amount is less than \$5 (or such other amount set by notice or other guidance by the IRS); and
 - (c) Take all reasonably available measures to reverse any ECA taken against the individual to obtain payment for the care. Such measures may include, but are not limited to, vacating any judgment against the individual, releasing a lien, and removing adverse information reported to a credit bureau.

5. In the case that an individual in already know to be FAP eligible for a 100% discount on charges, the individual will not receive a bill and not be eligible for ECAs. Individuals qualified for a 75% discount on charges will receive a bill for their portion owed and will be subject to ECAs on only to balance due from the patient.

If after receiving a FAP application DECH believes that the individual may qualify for Medicaid, DECH may postpone determining whether the individual is FAP-eligible until after the individual's Medicaid application has been completed and submitted and a Medicaid determination has been made.

III. ECAs that May Be Used

ECAs that may be initiated in accordance with this Policy are as follows:

- Accounts are reported to credit agencies such as Experian, TransUnion, and Equifax after 90 days of non-payment to the collection agencies assigned to the account.

- Liens on residences and lawsuits may be considered depending on the circumstances surrounding non-payment. All lawsuits must be approved by the CEO before implementation.

The Patient Financial Services Director in coordination with the CFO will ensure that the patient financial services department and processes have executed reasonable efforts to determine if an individual is FAP-eligible in accordance with this Policy before DECH engages in the above approved ECAs. Refer to the Financial Assistance Policy for further details.

BILLING PROCESSES:

INSURED PATIENTS

The Hospital will make diligent efforts to verify the patient's insurance status and assist the patient in complying with the requirements of their health insurance plan. Whenever possible, this verification will include a determination of the patient's expected financial responsibility, including applicable coinsurance, deductibles, and co-payments. 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, the Hospital 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 Financial Counseling.

- 1) Contracted Insurance Plans. The Hospital contracts with a number of insurance plans. In those cases, the Hospital will seek payment from the insurance plan for all covered services. Patient payment of all co-payments, deductibles, and co-insurance amounts may 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, the Hospital 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. The Hospital will extend the courtesy of billing a patient's insurance company in those cases where the Hospital does not have a contract with an insurer. While the Hospital 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 Hospital 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. Balances remaining after any insurance payment will be billed to the patient. Whenever possible, the Hospital 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.

UNINSURED PATIENTS (SELF/PRIVATE PAY)

Patients who do not have health insurance and have not been previously determined to qualify for the Hospital's Financial Assistance Program, will be asked to contact Financial Counseling and provide a deposit in advance of services not required to be performed by EMTALA. The deposit may be up to 100% of the estimated charges for the service to be provided, less any private pay discount. In those cases, where a precise estimate of the charges is not possible, the Hospital 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 will be asked to make contact to Financial Counseling prior to services being scheduled. All patients will be provided information on any hospital discount programs that are available to them. 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.

Hospital accounts are assigned to collection agencies alphabetically:

A-O = The Thomas Agency, PO Box 6759, Portland, ME 04103

P-Z= Advanced Collection Services, PO Box 7103, Lewiston, ME 04243.

All physician practice accounts are sent to Advanced Collection Services, PO Box 7103, Lewiston, ME 04243.

Hospital Accounts:

The hospital utilizes eManagement Associates (EMA) to manage its claim statement process. Patient bills are sent according to the frequency set by EMA as instructed by the hospital, beginning the day of discharge for self-pay patients, and following payment from insurance for patients with insurance. For hospital bills this frequency is as follows:

- If the patient balance is \$2.51 to \$5.00 one statement is sent. At day 30 the account is marked by EMA for write off (not placed with a collection agency).
- If the patient balance is \$5.00 and over, four statements are sent, with the final statement going out at day 90. At day 90 the statement informs the patient that the account will be sent to collection in 30 days if payment or arrangements are not made and that the collection agency may report the outstanding balance to the appropriate credit agencies. At day 120 the account is marked by EMA for collection. However, no accounts may be marked by EMA for collection or a report be made to a credit reporting agency unless all requirements under this Policy are met.
- This process is only utilized until if and when a patient asks to be, or is determined to be, eligible for payment arrangements with Carepayment.

Physician Office Accounts:

The physician practices use Centricity and eManagement Associates (EMA) to manage its claims statement process. Patient bills are sent on 30 day cycles for a total of three statements over 90 days. Patient bills are remitted to collection agencies 120 days after non-payment beginning the date that DECH provides the first post-discharge billing statement for care for self-pay patients, and following payment from insurance for patients with insurance. All other self-pay billing and collection procedures are the same as the hospital.

Payment arrangements may be made for accounts. Accounts that are under payment arrangements are sent monthly statements. If payments are made on a monthly basis as agreed, the account remains current. Upon 120 days without a payment, the accounts are marked for collection and go through the collection process; provided, however, that no accounts may be marked for collection unless all requirements under this Policy are met.

IV. Payment Arrangements and Prompt-Pay Discounts

Guidelines for payment arrangements:

Accounts are to be paid in full unless payment arrangements are made for the account.

Carepayment:

Effective 6-1-2017, patients who wish to pay their account balances through a payment plan will be referred to Carepayment for payment arrangements. Payment arrangements with Carepayment are as follows:

Term length	Account Balance	Monthly Payment
• 6 months	\$100.00-\$600.00	\$25.00-\$100.00
• 12 months	\$600.01-\$1200.00	\$50.00-\$100.00
• 24 months	\$1200.01-\$5000.00	\$50.00-\$209.00
• 36 months	\$5000.01 +	\$139.00 +

If a patient does not engage with Carepayment, or defaults on the payment arrangement, the account is returned to Down East Community Hospital and prepared for placement with a collection agency.

- Employees of DECH may make payment arrangements on hospital accounts through the payroll deduction process. This can be initiated through the PFS Director.
- Alternative payment arrangements may be made at the discretion of the PFS Director or Physician Billing Supervisor upon request of the patient.

Prompt pay discounts of 3% are offered for payment in full within 30 days of the patient being mailed a statement. This is for balances over \$100.00. Guidelines are as follows:

- Discounts will not be given on accounts that have been placed with collection agencies except in the case of settlements, and will only be granted by the PFS Director or CFO.
- Discounts may be considered on a case by case basis by the PFS Director with non-contracted insurance providers and payment must be made within 30 business days.

Prompt pay discounts of 5% will be given if the full estimated payment is made at the time of service. This does not apply to office copay amounts.

A discount of 15% will be assessed automatically on all private pay accounts at the time of billing.