DEPARTMENT POLICY

FRANCISCAN CARE SERVICES
dba ST FRANCIS MEMORIAL HOSPITAL,
dba DINKLAGE MEDICAL CLINIC AND ASSOCIATED CLINICS
WEST POINT, NEBRASKA

DATE ISSUED 01/01/16 **POLICY # 910.006**

REVISIONS 2/23/16 **REVIEWED 2/23/16**

SUBJECT BILLING & COLLECTION POLICY **DEPARTMENT BUSINESS OFFICE**

PURPOSE

The policy of Franciscan Care Services is to be proactive in collection efforts. This begins at the time the patient is registered and ends when the account balance has been paid in full.

REGISTRATION/TIME OF SERVICE:

The following items will occur at the time of service:

1. Complete demographic data will be obtained. Patients are required to show proof of insurance and provide information to admission personnel.
2. Third-party payer information will be obtained from the patient or responsible party. A copy of both sides of the insurance card will be taken.
3. Payment in full, or commitment of payment, will be requested when total charges are known at the time of service.
4. Co-payments are due at the time of registration. This includes co-pays for employees. Co-pays may be billed on the next billing if they are not known at the time of admission.
5. Questions regarding financial obligations will be directed to the Patient Financial Counselor. Questions unable to be resolved will be referred to the Business Office Manager.

PROCEDURE FOLLOWING DELIVERY OF SERVICES:

ITEMIZED BILLS:

One itemized bill will be sent to the patient if requested without charge. Additional copies, as well as copies of explanations of benefits and payment account summaries, will be charged at $0.25 per page. When copying EOB's or other documentation which has multiple patients, names and personal information of other patients should be blacked out or covered before releasing, to comply with HIPPA regulations.

NON-SUFFICIENT FUNDS CHECKS (NSF):

Checks returned for non-sufficient funds will be charged $20.00. The NSF check should be given to the Patient Financial Counselor to determine the next step in the collection process.

THIRD PARTY CLAIMS:

As a courtesy to the patient, third party claims will be submitted when the appropriate information has been provided to the staff of Franciscan Care Services.

WORKER'S COMPENSATION CLAIMS:

Worker's compensation claims will be sent directly to the employer to be filed. If the name of the worker's compensation carrier is available, the claim will be sent directly to the carrier. If a patient states a charge is work-related, then the claim will be sent to the carrier for determination. FCS staff will not determine the merit of worker's compensation claims.

OB CHARGES:

OB patients will sign a form outlining OB charges at the Dinklage Medical Clinic for the pregnancy and delivery. All deductible and co-pay amounts are to be calculated and paid PRIOR to delivery.

NON COVERED SERVICES:

Physicians may order services which are related to quality medical care, but not payable by the insurance carrier. Patients should be advised to refer to their Plan Handbook or Plan Exclusions for coverage determination. Examples of non-covered services may be screening exams or outpatient oral medications for Medicare.

PAYMENT IN FULL:

FCS will pursue payment in full on all private pay balances as the primary option to resolve the account. Statements will be sent out every month. Balances are due upon receipt of the statement. Payment in full may be made in one of the following ways:

1. Cash
2. Check
3. Credit Card (Discover, Visa, MasterCard)

PAYMENT ARRANGEMENTS:

In the event that your financial means are limited and you are not able to pay in full within 30 days after receipt of statement, financial arrangements for payment need to be established. The following policy will be followed:

If your account balance is:	Your monthly payment will be:
$0 - $500	$50
$501 - $1,000	$100
$1,001 - $4,150	$125
For amounts greater than $4,150	Monthly payment is 3% of total balance.

NOTE: Interest is not charged on outstanding patient account balances at this time.

The Business Office Manager/Patient Financial Counselor will have authority to authorize payment alternatives outside of this limit in special circumstances. In the absence of the Business Office Manager, where an immediate answer is required, contact the CFO. Payment arrangements do not automatically include new charges. Payments for new charges will be due and payable at the time of service, in addition to the previous payment arrangements. Again, it is to be stressed that current charges must continue to be met, in addition to the payment arrangements made by the patient.

FINANCIAL COUNSELING:

If a determination is made that the patient or responsible party is not able to pay the account in full, make satisfactory payment arrangements, or utilize other options, then referral to Medicaid or financial assistance programs should be made. Also, referrals to the Social Worker may be an option to assist patients.

FINANCIAL ASSISTANCE:

Franciscan Care Services has a financial assistance program to assist patients that are financially burdened and unable to pay for their medical expenses. A financial assistance application must be completed and turned into the Patient Financial Counselor. A copy of the most current tax return (IRS Form 1040 or 1040A) must accompany the financial assistance application. A determination of approval or denial is made from this application and is based upon hospital established guidelines. Note----The financial assistance program is a last resort for patients making a genuine effort to pay their bills. All other avenues for payment must be exhausted (such as a bank loan, Medicaid, disability, Kid's Connection) before this program applies.

COLLECTION ACTIONS:

Patients will be offered a plain language summary of the financial assistance policy upon admission to the Hospital. Furthermore, all billing statements will include a conspicuous written notice regarding the availability of assistance, including the contact information identifying where the patient may obtain further information and financial assistance-related documents and the website where such documents may be found.

The Hospital or its authorized representatives may refer a patient's bill to a third party collection agency or take any or all of the following extraordinary collection actions ("ECAs") in the event of non-payment of outstanding bills:

- Report information about an individual to a credit reporting agency or credit bureau
- Place a lien on an individual's property
- Foreclose on an individual's real property
- Attach or seize an individual's bank account or any other personal property
- Commence a civil action against an individual
- Garnish an individual's wages

The Hospital may refer a patient's bill to a collection agency 120 days from the date the first bill for care was provided to the patient. The Hospital will not take ECAs against a patient or any other individual who has accepted or is required to accept financial responsibility for a patient unless and until the Hospital has made "reasonable efforts" to determine whether the patient is eligible for financial assistance under this policy. The Patient Financial Counselor is responsible to determine whether the Hospital has engaged in reasonable efforts to determine whether a patient is eligible for financial assistance.

A. No Application Submitted

If a patient has not submitted a financial assistance application, the Hospital has taken "reasonable efforts" so long as it:

1. Does not take ECAs against the patient for at least 120 days from the date the Hospital provides the patient with the first post-discharge bill for care; and

2. Provides at least thirty (30) days' notice to the patient that:

    - Notifies the patient of the availability of financial assistance;

    - Identifies the specific ECA(s) the Hospital intends to initiate against the patient, and

    - States a deadline after which ECAs may be initiated that is no earlier than 30 days after the date the notice is provided to the patient;

3. Provides a plain language summary of the financial assistance policy with the aforementioned notice; and

4. Makes a reasonable effort to orally notify the patient about the potential availability of financial assistance at least 30 days prior to initiating ECAs against the patient describing how the individual may obtain assistance with the financial assistance application process.

1. If the patient has been granted financial assistance based on a presumptive eligibility determination, the Hospital has provided the patient with the notice required in the financial assistance policy.

B. Incomplete Applications

If a patient submits an incomplete financial assistance application during the Application Period, "reasonable efforts" will have been satisfied if the Hospital:

1. Provides the patient with a written notice setting forth the additional information or documentation required to complete the application. The written notice shall include the contact information (telephone number, and physical location of the office) of the Hospital department that can provide a financial assistance application and assistance with the application process. The notice shall provide the patient with at least 15 days to provide the required information; and

2. Suspends ECAs that have been taken against the patient, if any, for not less than the response period allotted in the notice.

If the patient fails to submit the requested information within the allotted time period, ECAs may resume; provided, however, that if the patient submits the requested information during the Application Period, the Hospital must suspend ECAs and make a determination on the application.

C. Completed Applications

If a patient submits a completed financial assistance application, "reasonable efforts" will have been made if the Hospital does the following:

1. Suspends all ECAs taken against the individual, if any;

2. Makes a determination as to eligibility for financial assistance as set forth in the financial assistance policy; and

3. Provides the patient with a written notice either (i) setting forth the financial assistance for which the patient is eligible or (ii) denying the application. The notice must include the basis for the determination.

If the Hospital has requested that the patient apply for Medicaid, the Hospital will suspend any ECAs it has taken against the patient until the patient's Medicaid application has been processed or the patient's financial assistance application is denied due to the failure to timely apply for Medicaid coverage.

If a patient is eligible for financial assistance other than free care, the Hospital will:

1. Provide the patient with a revised bill setting forth: (i) the amount the patient owes for care provided after financial assistance, (ii) how the revised amount was determined; and (iii) either the AGB for the care provided or instructions on how the patient can obtain information regarding the AGB for the care provided;

2. Provide the patient with a refund for any amount the patient has paid in excess of the amount owed to the Hospital (unless such amount is less than $5); and

3. Take reasonable measures to reverse any ECAs taken against the patient.

UNCOLLECTIBLE ACCOUNTS:

Accounts deemed uncollectible by the Patient Financial Counselor will be referred to our collection agency. Every attempt to collect the balance due must be made prior to assigning it to bad debt. Each communication with the patient/responsible party will be thoroughly documented to aide in litigation of the account if that should become necessary.

Accounts referred to a collection agency:

1. Each guarantor will receive 3 statements showing a balance due in the private pay column before going to a collection agency.
2. At 90 days, a collection letter will be sent requesting payment within 30 days.
3. If no payment is received within the 30 days, we will mail out a final collection letter. Payment will be expected within 10 days and the account will be listed in full collections with our collection agency in 20 days if payment is not received.
4. Documentation of all contacts with the patient should be documented in the Paragon computer software.

From this point forward, all communications with the patient or responsible party shall be directed to the collection agency. Payments received on bad debt accounts should be sent to the collection agency. If we receive a payment on a bad debt account, it should be given to the Patient Financial Counselor to make the final decision on whether to post the money or to mail the money to the collection agency.

Procedure for collection:

1. Account will be handled by the Patient Financial Counselor to file appropriate paperwork with the collection agency.
2. The Patient Financial Counselor will then write account off to bad debt.
3. Statements will not be generated for bad debt financial classes.
4. Cash received for bad debt accounts will be directed to the Patient Financial Counselor. The Patient Financial Counselor will contact the collection agency to let them know that we received a payment.

LIENS/ACCIDENT CLAIMS:

A lien will be filed on all accident claims over $100 to the insurance company. This includes automobile claims, personal injury claims (such as falling at another person's home, etc.)

If an insurance carrier is not settling timely, the billers may, in consultation with the business office manager, file for a provisional settlement with Medicare or Medicaid, if coverage is applicable.

BANKRUPTCY:

When the initial filing on a bankruptcy notice is received, it is to be given to the Patient Financial Counselor. Once we receive the final letter from the bankruptcy court we will write off the account(s) as charity. If the account(s) are already at the collection agency, we will need to reinstate the account from bad debt and then write them off as charity. Statements and collection attempts must stop at the time the initial bankruptcy notice is received. If insurance money can still be collected on an account, the collector may pursue this payment. Collectors will have to institute a manual system of following this claim to receive insurance payments. If all insurance payments have been received, the account can be written off as charity.

Notes should be placed on each account in the Paragon computer system affected by the bankruptcy indicating the date of the bankruptcy notice, date received and whether the account has been referred for bankruptcy write off.
If a patient/responsible party wishes to pay on an account marked as bankruptcy, payment may be accepted. We can not send a statement on the account, but they may make payments on the account.

OTHER:

This policy replaces policy number 950.072 – Collection Policy issued 4/02/04.