SELF PAY BILLING & COLLECTIONS PROCEDURES

I. PURPOSE: To establish logical, consistent methods of billing and collections follow-up for self-pay patient balances to ensure that all staff members possess a good understanding how to appropriately and effectively work these accounts. To ensure that all actions taken on every account are consistent, compliant, legal and ethical.

II. POLICY: It is the policy of Rice Memorial Hospital to implement billing and collections procedures that will equitably and proficiently facilitate the collection of self-pay balances. Employees of Rice Memorial Hospital are strictly forbidden from displaying behavior that is abusive, harassing, oppressive, false, deceptive or misleading to the patient or any other customer.

III. RESPONSIBILITY: Business Office Staff - CEO and Board

IV. SELF-PAY BILLING

1. Self-pay will not be billed until after all known insurances have been billed and either a paper explanation of benefits (EOB), an 835 electronic remittance advice (ERA) has been received, or communication with the payer has been performed and established that patient is responsible for ending balance and this is documented within the patients file (any amount being billed to the patient greater than one year old must be approved by the direct supervisor). Billing the patient will depend on whether or not the patient has been contacted by the Business Office during the last 12 months. If Rice Memorial Hospital did not follow-up with the patient to inform them that the claim was still actively being worked, the patient would not be billed and their responsibility would be written-off.
   a. A “Patient Responsibility” code related to copay, coinsurance, deductible, spenddown or denial for self-administered drugs is received from insurance either on a paper EOB or through an 835 ERA, or amounts unpaid by a non-contracted entity.
   b. Eligibility “Patient Responsibility” code unrelated to bullet “1” that is deemed patient responsibility is received from insurance (Group Code is equal to PR) **and:**
      1. A complete eligibility investigation must be performed AND documented in the patient’s notes before the account is turned to self-pay
   c. If additional information from the patient is requested by Rice or their insurance before any claims can be adjudicated and it is clearly documented in the patient notes that the patient has not complied with the request after three attempts, each performed 7 days apart. Contact attempts to the patient must include two phone calls and a letter.
   d. Patient participates in a health care sharing plan is considered self-pay.
   e. Patient has a MN Medicaid restricted coverage plan and obtains services from Rice where Rice is not the restricted provider. Registration will attempt to obtain an ARN and

note the account. A referral from the primary care physician will be attempted to be collected for an appeal with the payer. Patient collections may be pursued without obtaining a PR denial from MN Medicaid. Two statement notifications are to be sent to the patient in an attempt to collect the outstanding debt and if unsuccessful the balance will be written off to uncompensated care and approved by the director/supervisor.

f. Patient has an out-of-state Medicaid plan and obtains services from Rice where Rice is not a contracted provider. The claim does not need to be billed to the out-of-state Medicaid plan, the balance will be written off to uncompensated care and approved by the director/supervisor.

g. Patient has Emergency Medicaid plan; registration will attempt to obtain an ARN and note the account. Financial Advocate will work with appropriate department director to obtain a care plan. If successful the claim will be resubmitted to Medicaid for processing. All remaining balances will be written off to uncompensated care and approved by the director/supervisor.

h. Patient has Family Planning Medicaid; registration will attempt to obtain an ARN and note the account. Financial Advocate will work on gathering additional coverage information for the patient. All remaining balances will be billed to the patient and pursued through collections and Minnesota revenue recapture after receiving three statements.

i. Patient has HH Medicaid plan; Financial Advocate will work on gathering additional coverage information for the patient. All remaining balances will be billed to the patient and pursued through collections and Minnesota revenue recapture after receiving three statements.

V. SELF-PAY BALANCES

1. Patient portions will be billed after all efforts to bill any third party payers have been exhausted, it has been <u>determined to the best of our ability that the patient does not carry any third party coverage,</u> and no other party other than the patient is liable for the charges. Any amount being billed to the patient greater than one year old must be approved by the Director of Revenue Cycle.
   a. Billing the patient will depend on the account has being actively worked by the Business Office during the last 12 months.
2. Payments are due according to the definitions outlined in the RMH Patient Access Procedure Section IV.D.
3. If patient expresses an inability to pay in full the Financial Advocate will discuss other options with the patient and document the discussion in patient notes:
   a. Loan or Credit Card.
   b. If a patient expresses an inability to pay according to our guidelines a financial assessment will be completed with the patient. If the financial assessment supports the patient's claim and the patient would not qualify for Rice Trust Grant or Rice Matching Grant then a payment plan appropriate to the patient's income and balance on their account will be suggested. For accounts greater than $500 and the patient is unable to pay

outstanding balance within six months, the patient will be directed to the patient financing loan program. Any payment plan that exceeds the thresholds established in the patient financing loan program will be approved by the Director or Manager. Qualified patients must have a new financial assessment completed 12 months from the original assessment date to monitor changes in income and necessary expenses.

c. Application for Medical Assistance.

d. Application for Rice Trust Grant and Rice Matching Grant (see RMH Financial Counseling Policy & Procedure Section VIII).

e. Other items can be discussed at the discretion of the Financial Advocate.

4. A prompt pay discount of 10 percent will be offered to all patients who pay prior to receiving services and/or up to the prompt payment due date printed on their first statement.

   a. Self-pay only services not billable to insurance will not be eligible for the prompt pay discount. These dues are to be collected prior to services being rendered.

5. Refunds must be made within 30 days after the date of receipt of the remittance advice if there is not a review of the account for a denial or appeal (refer to the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 30, Section 50.13 for additional information)

   a. If the patient has additional accounts with outstanding balances, the credit balance can be applied to other accounts. Notification to the patient must be completed via phone informing the patient of the balance transfer. If the patient is unable to be notified via telephone within 7 days, a letter will be sent to the patient notifying them of the balance transfer.

   b. If a patient has upcoming visits scheduled, the financial advocate can call the patient and receive approval to hold the credit until the future service are rendered and may apply the credit to the corresponding account.

   c. If a refund is owed due to an overpayment from Minnesota Revenue Recapture, the state must be notified to determine if the patient has other outstanding debts with the state. If outstanding debt is still owed to the state by the patient the refund must be made to the state. If no outstanding debt is owed to the state by the patient the refund must be made to the patient in addition to a $15 processing fee.

6. Delinquent accounts will be forwarded to an outside collection [bad debt] agency and submitted to the Minnesota Revenue Recapture Program. Balances must not be combined from other accounts. Balances forwarded to a collection agency and Minnesota Revenue Recapture should be reflective of the date of service for that account only.

   a) Balances $14.99 and under will not be submitted and pursued by collection agencies. Two statement notifications are to be sent to the patient in an attempt to collect the outstanding debt and if unsuccessful the balance will be written off to bad debt.
   b) Balances $24.99 and under will not be submitted to the Minnesota Revenue Recapture program for collection.
   c) Patients with remaining copay/deductibles with Minnesota Medicaid will not be submitted into Minnesota Revenue Recapture due to the income guidelines established by the state of Minnesota statute M.S. 270A.03 subd 5.
   d) All billings and attempts to contact the patient will be documented in patient notes.

e) Payment plans will not be started until the first payment is received. Existing payment plans will be considered delinquent after one missed payment. The patient will have 30 days to become current with their payment plan.
f) Patients will receive three notifications approximately 30 days within each other requesting payment on account except in cases of mail return. Phone attempts to contact the patient should be made between the second and third notice for account equal to or greater than $500.
g) If the patient's address cannot be obtained and the patient is not available by phone the account will be forwarded to a collection agency.
h) If no payment is received 30 days from the final notice or payment is received but not in conjunction with an agreed upon payment plan the account will be forwarded to an outside collection agency.

VII. PATIENT CONCERNS AND COMPLAINTS

1. Telephone calls to the Business Office by patient should be returned within one business day. Written correspondence from patient shall be responded to within ten business days.
   a. Collection activity will not be pursued for thirty days after the patient has been responded to in the event that a patient advises that they do not owe any or part of the bill, that the bill should be paid by a third party or that documentation is needed. If this is the case, Rice Memorial Hospital staff should contact the patient to coordinate benefits and help facilitate reimbursement from responsible parties.
2. Complaints and disputes should be documented using the online reporting system found on RiceNet.
3. Collection activity on accounts that are directly related to the patient complaint should be suspended for 30 days after the complaint has been resolved.
4. Comments regarding high prices will not be regarded as complaints.

VIII. THIRD-PARTY COLLECTION AGENCY

1. Rice Memorial Hospital
   a. May discuss account information that occurred prior to the collection agencies' involvement with the patient.
   b. Will not discuss payment arrangements with a patient who has been referred to its third-party collection agency, but shall refer the patient, in a courteous manner, to the collection agency for arrangements.
   c. Expects its collections agency to abide by the same standards as Rice, and will not tolerate disrespect to its patients referred to the agency.
   d. Will have its Director or Manager review all complaints concerning its third-party collection agency on a bi-monthly basis.
   e. Will have its CEO review the contract between collection agency and Rice Memorial Hospital annually.
   f. Will not report a patient to a credit agency unless the patient fails to pay their debts to Rice, and their debt goes to judgment.
2. Garnishments

a. The Director or Manager must review and authorize any garnishments before pursued by a collection attorney. All collection and charity efforts described in the P&P must have been exhausted.
b. Before any wages can be garnished from a patient a judgment must first be obtained.
c. Any written claims from the patient stating they are exempt from the garnishment must be reviewed by the Director or Manager before garnishment may be pursued by the attorney.

3. Litigation
   a. The Director or Manager must review, authorize and sign pleadings for any debt collection litigation before pursed by its collection attorney.
   b. All collection and charity efforts described in this P&P must have been exhausted.
   c. Lawsuits brought against patients must be pursued within several days after the lawsuit has been served upon the patient.
   d. Rice Memorial Hospital will not allow any debtor to be arrested as a result of the debtor's failure to appear in court, complete paperwork or respond to any request or action with the attempt to collect medical debt.
   e. If Rice has any knowledge of the identity of any attorney representing a patient in connection with Rice's collection efforts, we will notify our debt collection attorney.

IX. RICE MEMORIAL HOSPITAL'S BOARD OF DIRECTORS

1. Annually the Board will review:
   a. The practices of Rice Memorial Hospital's debt collections litigation against its patients.
   b. The debt collection activity of its third party debt collection agency.
   c. The debt collection activities of its internal debt collectors.
   d. The hospital's compliance with the agreement with the State of Minnesota Attorney General.
   e. The results of the CEO's review of:
      (1) Rice Memorial Hospital's contract with its third party collection agency.
      (2) The practices of its third party collection agency and debt collection attorney.
      (3) Rice Memorial Hospital's Charity Care practices.