

<b>POLICY TITLE:</b> Credit Collections	
<b>APPLICABLE FACILITIES:</b>	
<input type="checkbox"/> EHC	<input type="checkbox"/> EDH
<input type="checkbox"/> EHH	<input type="checkbox"/> EHI
<input type="checkbox"/> EHN	<input checked="" type="checkbox"/> EJCH
<input type="checkbox"/> ELTAC	<input checked="" type="checkbox"/> ESJH
<input checked="" type="checkbox"/> EUH	<input checked="" type="checkbox"/> EUHM
<input type="checkbox"/> EUHS	<input checked="" type="checkbox"/> EUOSH
<input checked="" type="checkbox"/> EWWH	<input checked="" type="checkbox"/> RJV-ERH
<input type="checkbox"/> RJV-ESOP	<input checked="" type="checkbox"/> TEC/ESA
<b>EFFECTIVE DATE:</b> 8/27/2018	<b>ORIGINATION DATE:</b> 10/28/16

**SCOPE:**

Emory Healthcare Revenue Cycle Operations, Finance, and Administration

**PURPOSE:**

To describe the principles underlying how Emory Healthcare Revenue Cycle Operations conducts business with its patient customers.

**POLICY STATEMENT:**

Emory Healthcare (EHC) is a not-for-profit organization dedicated to providing a high standard of health care services and maintaining a leadership role in the medical community. In order to provide these services, it is necessary that the institution maintain a strong financial position. Prompt collection of patient accounts receivables is a major portion of that position. While this policy establishes guidelines by which credit is issued to ensure the recovery of patient accounts, it is the policy of the organization that any patient requiring emergency medical treatment will be provided appropriate medical treatment within the capability of the hospital without regard to the patient's ability to pay given the services are available only at EHC or not reasonably obtainable at another facility.

EHC provides health care services to all individuals without regard to race, creed, national origin or ability to pay. Emory Healthcare is a major healthcare provider that operates solely on patient service funds and does not supplement operation expenses from any state or local tax revenues. EHC has fulfilled all requirements of Hill Burton funding. Every effort is made to secure optimal reimbursement for services rendered, including, where necessary, the option of litigation

**INPATIENT POLICIES**

- Wherever possible, all elective admissions are pre-admitted and third party coverage verified electronically prior to actual admission.
- Preadmission deposits are required if a patient does not have adequate insurance or insurance is not verified prior to admission. They are based on estimated liabilities calculated from average charges on similar cases.
- If third party coverage is denied or verified at less than optimal coverage, the Admitting/Business Office is responsible for resolving the financial arrangements in accordance with the following principles:
  - Payment of estimated patient/guarantor financial responsibilities prior to admission is based on a combination of average daily charges times the number of days expected

for length of stay, deductible, non-covered charge and other identified liabilities or a specific DRG's average charges.

- Patients are contacted after calculation of estimated liabilities to be advised of expected co-insurance expenses and to secure verbal agreement on coverage of patient liabilities. This notification may occur from either the Clinic or hospitals, depending on physician preference.
  - Patients receive a financial evaluation to secure acceptable financial payment arrangements.
- If the hospitals representative is unable to make acceptable financial arrangements, admission to Emory Healthcare may be postponed until such time when the account can be financially secured or alternative arrangements made. Before postponement of the admission occurs, representative confers with the Assistant Director - Admissions or Director of Patient Accounts before notifying the physician.
  - In cases where a third party payer has preadmission requirements (i.e. precertification, second surgical opinion, etc.), these requirements must be met or the admission may be postponed.
  - In compliance with federal regulations governing anti-dumping of patients EHC attempts to verify financial arrangements for patients scheduled as incoming transport except in medical emergencies. Financial arrangements include, but are not limited to, third party, self-pay or special program funds. EHC may elect not to accept an incoming transport due to lack of available rooms/beds conducive to a patient's needs. EHC staff who suspect a patient is the victim of "patient dumping" should report the incident to the Director of Patient Access for administrative follow-up prior to the case being accepted for transport and/or admission.
  - Any decision to deny inpatient admissions based on financial or precertification considerations must be approved by the Assistant Director of Access, Director of Patient Access or Care Coordination Manager, and the denial communicated immediately to the admitting physician.
  - Refusal of elective inpatient admission may occur under the following circumstances:
    - A patient refuses to make financial arrangements or provide financial information
    - An admitting physician either fails or refuses to provide sufficient data to evaluate the patient financial abilities.
    - Patient's condition does not meet admission criteria as governed by the respective third parties.
  - Admitting physician is notified when a patient's admission is refused with the recommendation that the admission be deferred until appropriate criteria are met and to ascertain that no emergent circumstances requiring admission exist. Exceptions must be approved on a case by case basis through hospital Administration.
  - Any case planned for cardiac-related services may be accepted without regard to financial coverage.

### EMERGENCY POLICIES

- Patients presenting themselves for emergency services are provided an appropriate medical screening examination. Any patient who is in need of immediate emergency medical services is provided services regardless of ability to pay.
- Patients requiring emergency medical services are admitted to EHC without regard to their ability to pay.
- After the patient's medical condition has been stabilized, insurance information is obtained from the patient or patient's family.
- If it is determined that there is no insurance or inadequate insurance and the guarantor is not in a financial condition to meet the obligation to the hospitals, the hospitals representative attempt to assist in making application for other financial coverage. If other financial coverage is unavailable, the financial counselor screens the patient for ability to pay or eligibility for charity care in order to properly classify the account.
- Under no circumstances are emergent patients denied treatment based on ability to pay if EHC is the only available facility or is the closest facility in the region for planned services.

### OUTPATIENT POLICIES

- EHC provides hospital insurance billing for outpatients who provide coverage information through the registration process.
- Patients are registered on a walk-in basis unless other arrangements are made to pre-register the account. Insurance is verified prior to the date of service if the projected account balance warrants, on a case by case basis.
- Whenever possible, patients are notified before or on the date of service regarding their financial responsibility. Payment arrangements are based on a schedule and are requested to cover all estimated patient responsibilities. Exceptions may only be made in advance of service in accordance with hospitals policies governing use of charity or indigent funds.
- If a patient does not have an insurance card available at registration, the account is established as self-pay. Exceptions may be made if a recent account exists on patients with positive payment experience.
- Deferral of services for outpatients is handled in the manner described for inpatient admissions.

### THIRD PARTY LIABILITY

Third party liability cases for automobile accidents and workers compensation are the personal responsibility of the patient who receives the care and are handled as private pay accounts except where other requirements are stipulated under state law. At the discretion of the financial counselor

or supervisory staff, exception to this rule may be made if the involved insurance company guarantees payment to the hospitals and coverage is verified in advance.

### DEPOSIT REQUIREMENTS

- Inpatient - Preadmission deposits are required if a patient does not have adequate insurance or insurance is not verified prior to admission. They are based on estimated liabilities calculated from average charges on similar cases.
- Outpatient - Elective outpatient surgery deposits are based on an estimate of hospital-based charges for the projected time required for each surgical case. Payment in full prior to surgery by cash, check or credit card is required of outpatient accounts unless confirmed coverage exists. If payment in full at discharge is not secured, the balance is due and payable 30 days following receipt of initial billing unless other arrangements have been made.
- Exceptions - Exceptions to deposit requirements/financial approval for a case may be made in accordance with administrative directives, i.e. cardiac-related cases.

### BILLING/FOLLOW-UP POLICIES

Insurance and Other Third Party Coverage - Final insurance claims drop no sooner than four days after inpatient, observation and recurring accounts are discharged or outpatient/ emergency services are performed. This allows sufficient time for charges to post, MR coding to occur and other billing-related information to be collected. Hospitals send claims to both primary and secondary payers and perform rebills as necessary in the course of insurance follow-up. Interim claims may be filed prior to final billing for inpatients with stays over 30 days. Claims are transmitted electronically to payers but occasionally may be mailed.

Patients - Summary patient bills drop concurrent with final insurance claims. If the account is self-pay, the summary bill drops four days after inpatient discharge or outpatient/emergency service. Bills are mailed and/or patients may opt to view their bills on-line. Patients receive periodic follow-up statements and may request itemized bills by contacting the Customer Service Department.

### COLLECTION POLICES

#### **Patients with Health Insurance**

EHC provides for filing of insurance claims as a courtesy service on behalf of the patient/guarantor. Although there are known timing factors before insurance payments are received, the patient/guarantor is always ultimately responsible for financial liability of the account balance and is billed if insurance does not pay promptly.

- If the insurance cannot be verified while the patient is inhouse, payment may become the responsibility of the patient/guarantor.
- Not less than four days after discharge, the final bill is generated and the insurance carrier(s) billed. The hospitals pursue verified accounts with the insurance carrier for a maximum of 60 days. If payment has not been received by the carrier within 60 days, payment may become the responsibility of patient/guarantor. Exceptions: Medicare, Medicaid, Blue Cross, Tricare and managed care contracts requiring final diagnosis. Variations to timing of bills may vary

based on patient type (i.e. inpatient versus outpatient) and insurance requirements. However, once a bill is generated, timing of collection practices and payment requirements is the same.

- The guarantor is responsible for the portion of the bill not covered or unpaid by the patient's insurance. The balance is payable in full when the patient receives the first statement showing an actual patient balance. Monthly payment terms may be granted by the business office in accordance with self-pay policies.
- The delivery of services as a health care provider is based on an assumed ability of the patient/guarantor to provide for financial arrangements through either third party or self-pay means. The exceptions are only those cases classified as medical emergency as defined in the body of this policy or any other approved program through Administration. All patients who receive services which are deemed non-covered subsequent to delivery of treatment are responsible for the full financial liability of the account unless collection is prohibited by a term of the contract or law. This applies to known "non-covered" services that are deemed as such after treatment regardless of circumstances, e.g. research cases not covered under a pre-approved fund.

### **Self-Pay Patients**

- Self-pay patients are those who do not have health insurance and are personally responsible for the entire bill.
- Payment for all self-pay liabilities, including those with delinquent prior service, is due prior to or at the time of admission or treatment unless other arrangements are secured through the financial counselor.
- Financial counselors interview all self-pay patients for ability to pay. Elective admissions are contacted by telephone to complete this interview whenever possible. The determination is decided from the patient filling out a financial application or online financial screening tool. Proof of income may be required before any adjustment is made. Financial counselors also assist with financial arrangements such as monthly payment schedule.
- EHC maintains recommended payment guidelines based on patient liability amount and payment. The goal is for accounts to be paid within six months. Reduced payment schedules may be made under an external payment tracking arrangement.
- Self-pay patients who pay their accounts are eligible for a self-pay discount on balance due.
- Services for elective patients who do not agree to payment schedules may be deferred until suitable financial arrangements are made. Financial counselors consult with patients' physicians to discuss options on a case by case basis.
- EHC is obligated to accept monthly payments lower than normal standards for patients undergoing emergency services. However, every effort is made to have the patient obtain a loan or pay the account off within six months prior to subsequent external collections or payment tracking.

- Patients making monthly payments are advised that their accounts may be referred to an outside organization for management purposes.
- Patients with payment arrangements who miss two or more consecutive payments are subject to assignment to outside agencies.
- Exceptions may be made in response to administrative directives, i.e. cardiac-related accounts.

### **Outside Agencies**

- EHC contracts with outsourced services to pursue collection of outstanding accounts. Agencies are selected according to their willingness to conform to the philosophy of the hospitals and their performance in collection activity and reporting. All unpaid accounts without prior exception or payment arrangements are placed with an outsourced service based on a predetermined time interval from the patient's first bill. Accounts that require special collection activity, like skip tracing and litigation, may be referred to outside collections at any time
- When an account has been placed for collection with an outside agency, the hospitals' contract with the patient or other representatives is restricted. Inquiries on outside collection agency accounts are directed to the appropriate agency.
- Recall of accounts from collection agencies must be approved by supervisory staff or higher from Revenue Cycle Operations.
- Bankruptcy accounts should never be placed with a collection agency.
- EHC instructs its collections agencies not to report patient data to the various credit bureaus.
- Other Reasons for Discretionary or Agency Placements
  - Patient refuses to apply for Medicaid
  - Inability to locate address
  - Patient stops making or skips monthly payments
  - Patient receives third party money
  - More than one insurance carrier is involved and neither takes responsibility (these accounts are immediately sent to a collection agency for special handling)
  - Litigation (sent to collection agency for special handling)
  - Expired - no estate (bad debt but not sent to external agency)
  - Bankruptcy (bad debt but not sent to external agency)
  - Precertification

### **Charity Service Expense**

- EHC renders uncompensated medical care to patients who are not eligible for outside financial aid or government-supported health care programs. Charity services are determined prior to admission for non-emergent inpatients and as soon after admission as possible for emergency patients.

- Charity write-offs may not be considered until the guarantor completes a financial application and shows proof of income unless a patient is eligible for a fund. Alternatively, the account may qualify for a charity write-off if patient falls below pre-determined Federal Poverty Level guidelines as determined by an online financial screening tool query. When these factors are completed, a financial means test is performed based on poverty guidelines set forth by the federal government. If the test indicates that the patient is medically indigent, the account is adjusted using a specified service code base on the charity category used. All adjustments are reflected on a monthly report from the general ledger and may be subject to review by administration.

### **Bad Debt**

- Accounts that have been billed and not paid for a period of no less than 60 days from billing may potentially be assigned a bad debt classification and handled as follows:
  - After the insurance bill date, the account is transferred into collections/insurance follow-up.
  - Collections attempts to make contacts by telephone or letter to secure insurance payments or make financial arrangements if insurance has not paid within 60 days. Timing for outpatient notices may be sooner than 60 days.
  - If collections cannot contact the patient by telephone, a notice is sent via mail.
  - After the first notice is sent and payment has not been received or the patient has not contacted a financial counselor or collections to make arrangements, the account may be written off to bad debt and referred to external collections.
  - Medicare accounts are held for 120 days from the date of the first letter to the patient.

### **Litigation**

- Emory Healthcare reserves the right to pursue litigation on unpaid patient accounts.
- Collection agencies are not authorized to pursue litigation or to seek judgement on any unpaid accounts without written consent of the Director of Revenue Cycle or designee.

### **Charity** (See Financial Assistance Policy)

Charity classification is in accordance with federal income poverty guidelines as well as both restricted and unrestricted fund charity programs.

### **Private Room Adjustment**

Emory Healthcare adjusts the difference between a semi-private room rate and private room only if the patient is placed in a private room for the convenience of the hospitals.

### **Allowances, Write-offs, and Discounts**

- Third Party Contracts: Contract allowances or discounts must be negotiated by the managed care officer, assistant director patient financial services or director patient financial services. Allowances are manually adjusted either at time of billing or at remittance payment from vouchers. Third party discounts must be negotiated in advance of service rendered.
- Write-Off Approvals: All accounts adjusted for discretionary or administrative write-off are reviewed by the appropriate business office supervisor, manager or director as follows prior to final approval by the senior associate hospital director/CFO or designee:

- \$5001 - \$10,000, Managers
- \$10,001 - \$24,999, Assistant Directors Patient Financial Services
- Over \$25,000 - Director Patient Financial Services

NOTE I: TEC write-off approvals are set to be no greater than the thresholds above. i.e: Managers may be required to write-off balances less than \$5,001.

NOTE II: Upon review by the CFO, any unapproved adjustments are reversed and the account re-established. Bad debt-related adjustments do not require administrative review as long as they are handled in accordance with steps defined in Section VI, E-Bad Debt. Otherwise, they follow the above approval process.

- Small Balances
  - Patient balances after insurance are billed for 30 days and subsequently written off if unpaid in accordance with the above dollar limits.
  - Refunds are not made on accounts with less than a \$50.00 credit balance unless requested by the patient.
  - In some circumstances, small balance write-offs may exceed \$50 at the discretion of revenue cycle leadership.

**RELATED DOCUMENT(S)/LINK(S):**

Pending

**DEFINITIONS:**

- Elective services are defined as medical or surgical cases that can safely be rescheduled or postponed pending satisfactory financial arrangements without posing any serious compromise of the patient's condition.
- Emergency services are defined as cases, which, if delayed, pose serious threat to the patient's condition.
- Outpatient surgery is defined as cases handled through any ambulatory surgical unit within the hospitals.
- Recurring is defined as a repeat outpatient case for services in the same unit/area with the same diagnosis.
- Litigation is defined as the process of engaging in legal proceedings in a court of law.
- Patient dumping is a statutorily imposed liability that occurs when a hospital capable of providing necessary medical care transfers a patient to another facility or turns the patient away because of the patient's inability to pay for services.

**REFERENCES AND SOURCES OF EVIDENCE:**

n/a