

**SINAI HOSPITAL OF BALTIMORE
Debt Collection Policy**

SCOPE: Sinai Hospital of Baltimore (Hospital)

RESPONSIBILITY: Patient Financial Services

PURPOSE: Sinai Hospital, when possible, attempts to collect estimated patient liability prior to or at time-of-service. Patient statement collection cycles and telephone communication is utilized to facilitate collection activity occurring post time-of-service.

Sinai Hospital contracts with third party receivables management agencies to provide extended business office services and insurance outsource services to ensure maximum effort is taken to recover self-pay and insurance receivables prior to transfer to bad debt.

Sinai Hospital also contracts with third party collection agencies to assist in the recovery of bad debt dollars after all internal collection efforts have been exhausted. In so doing, the collection agencies must operate consistent with Sinai Hospital's goal of maximum bad debt recovery and strict adherence with Fair Debt Collections Practices Act (FDCPA) rules and regulations, while maintaining positive patient relations. Contracts specify general scope of work and collection activity to be performed by the outside collection agency. Sinai Hospital and its agents shall assist uninsured and underinsured patients and eligible family members with the Financial Assistance application process in accordance with hospital policy. Sinai Hospital and its agents shall refrain from any debt collection activities against claimants with the Criminal Injuries Compensation Board (CICB) pursuant to Senate Bill 115 and shall operate in accordance with its policy. Additionally, Sinai Hospital is prohibited from selling any debt.

POLICY: It is the policy of Sinai Hospital to ensure that all patient accounts are handled consistently and appropriately to maximize cash flow and to identify bad debt accounts timely. Active receivables are written-off and convert to bad debt accounts when they meet established collection activity guidelines and/or are reviewed by appropriate Patient Financial Services management and determined uncollectible revenue. Every effort is made to identify and pursue all account balance liquidation options including, but not limited to third party payer reimbursement, patient payment arrangements, Medicaid eligibility and Financial Assistance.

The Board of Directors shall review and approve the Debt Collection Policy every two years. The hospital may not alter its Debt Collection Policy in a material way without approval of the Board of Directors.

Original Date: 12/08
Revised Date: 10/10
Approvals: 04/11; 03/13; 04/16; 01/18

Board of Directors Approval

Anthony K. Morris



Corporate Vice President
Chief Revenue Officer

1/25/2018
Date

1/31/18
Date

William H. Rew



Director/Patient Financial Services

1/30/2018
Date

Procedure:

The Hospital will ensure third parties collecting on its behalf provide statements that contain Financial Assistance information including how and where to apply, where to find information including: on-line, in person at the hospital and by telephone.

The Hospital will ensure third parties collecting on its behalf do not initiate Extraordinary Collection Actions (EACs) until at least 120 days from the date the first post-discharge billing statement is provided.

I. Early-Out Self-Pay (EOS) – Outpatient

- A. Information Systems will generate an itemized bill for outpatient self-pay accounts based on established systematic bill holds.**
- B. Information Systems will generate a file of outpatient self-pay accounts for placement to EOS vendor(s). This process will include assigning the appropriate outsource code based on a pre-determined alpha-split, to identify EOS vendor.**
- C. Information Systems will deliver daily to the EOS vendor the placement file, containing patient demographic, insurance, documentation and charge data. Information Systems will send an email summarizing the number of accounts and total dollar amount placed.**
- D. EOS vendor will load placement and send hospital an acknowledgement, validating receipt of placement.**
- E. Hospital Collections Liaison will reconcile placement summary against acknowledgement and resolve variances. Variances remaining unresolved more than one business day will be reported to Manager, Billing Operations and Director PFS.**
- F. All patient inquiries received by the hospital, where it is not evident that a complaint or dispute exists, will be referred to the appropriate EOS vendor for handling.**
- G. EOS vendor initiates defined workflow process, to include outbound telephone calls and mailing statement/invoices to guarantor.**
- H. EOS vendor attempts to –**
 - develop insurance information not provided at time of registration**
 - obtain payment in full**
 - establish acceptable payment plan**
 - investigate guarantor's ability to pay based on income/assets and make financial assistance referral as appropriate (refer to in-house Medical Assistance Eligibility department or send Financial Assistance application and make referral to hospital)**
- I. If successful, the EOS vendor will hold the account until it is resolved.**
- J. If unsuccessful 120 days from the date the first post-discharge billing statement was provided, EOS vendor will transition accounts to internal bad debt workflow process. Note: The vendor's classification of active AR or bad debt does not effect the hospital's classification of the account.**
- K. If unsuccessful after 180 days, EOS vendor prepares a close file on a monthly basis for return to the hospital.**
- L. Closed files are received by hospital Information Systems, outsource codes are updated to reflect the new assignment to the second agency and placed with the second agency on a monthly basis. Information Systems provides second placement information to hospital Collections Liaison.**
- M. EOS vendor loads second placement and sends hospital an acknowledgement, validating receipt of placement.**

- N. Hospital Collections Liaison reconciles placement data against acknowledgement and resolves variances. Variances remaining unresolved more than one business day will be reported to Manager, Billing Operations and Director PFS.
- O. EOS vendor initiates defined second placement workflow process, to include outbound telephone calls and mailing statement/notices to guarantor.

II. Inpatient Self-Pay

- A. Self-Pay Advisor in Patient Access processes patients admitted as self-pay (without insurance).
- B. Self-Pay Advisor screens patients for third party insurance as follows:
 - check ALL prior registrations
 - check HDX
 - check EVS/MA eligibility
 - check Medicare (if over 65 years old or indication of disability)
 - check other automated websites
- C. Self-Pay Advisor interviews patient, face-to-face or by telephone and completes Self-Pay Checklist (Attachment #1).
- D. Self-Pay Advisor updates patients for whom insurance is developed, or is able to make payment in full or establish acceptable payment arrangements. Patients who do not have the ability to pay are referred to MA Liaison for further review.
- E. MA Liaison interviews patient face-to-face or by telephone for consideration under Sinai Hospital's Financial Assistance program and/or continuation of Medical Assistance interview as appropriate. A Financial Assistance application is completed with the patient whenever possible and retained on file for future use.
- F. MA Liaison determines potential for Medical Assistance eligibility and initiates application process. Attending physician and Department of Social Services on-site worker is contacted to complete necessary forms and set Medicaid interview date and time.
- G. MA Liaison continues to manage patient application while in-house and after discharge until Medicaid eligibility determination is made.
- H. If account was outsourced to an MA Eligibility agency contracted by Sinai Hospital, the agency continues to manage patient application process.
- I. If determined eligible, MA Liaison will update system accordingly and oversee the billing process until paid.
- J. If determined ineligible, MA Liaison will forward Financial Assistance application and supporting documentation collected during the MA eligibility process to Financial Assistance Technician for review.
- K. Financial Assistance Technician will process application and render a decision of eligible or not eligible based on procedure. A letter to patient/guarantor will be sent advising outcome.
- L. Account balances will be adjusted in accordance with the Financial Assistance policy/procedure. If ineligible, due to overscale income or uncooperative, patient will be reviewed for referral to bad debt collection agency.

III. Patient Liability After Insurance/Bad Debt Collection Agency Referrals

- A. Sinai Hospital will provide for active oversight of any contract for collection of debts on behalf of the hospital.

- B. Accounts qualify for bad debt after all third party payer reimbursement and insurance liability is exhausted and**
- C. Accounts qualify for bad debt based on number of statements/invoices and/or age of account (120 days from the date the first post-discharge billing statement is provided). Transfer to bad debt may be accelerated or delayed based on certain situations including but not limited to: returned mail, missed payment and/or defaulted payment contracts.**
- D. Accounts may be flagged for bad debt manually or automatically (via the system). Information Systems selects accounts meeting bad debt criteria nightly and assigns appropriate out-for-collection code based on alpha-split assignment. Weekly files are generated on Sunday, to include accounts selected on the prior Monday through Sunday.**
- E. All patient inquiries received by the hospital, where it is not evident that a complaint or dispute exists, will be referred to the appropriate collection agency for handling.**
- F. Bad Debt Types –**
 - Patient who is clearly not a Medicaid candidate due to medical and/or financial consideration
 - Patient who was Medicaid pending for outstanding bill(s) and was determined to be ineligible or uncooperative
 - Patient who was processed for Financial Assistance for outstanding bill(s) and was determined to be ineligible or uncooperative
 - Patient who was processed for Financial Assistance for outstanding bills(s); approved for Financial Assistance with a patient resource and then failed to pay patient resource amount
 - Patient who contracted to pay outstanding bill(s) and failed to adhere to contract
 - Patient who failed to respond to contact attempts
 - Patient that cannot be located via mail or phone attempts (SKIP)
 - Patient for whom all other collection efforts have been exhausted
- G. Information Systems will generate a file of accounts qualifying for bad debt placement to agencies. This process will include assigning the appropriate out-for-collection code based on a pre-determined alpha-split, to identify bad debt agency.**
- H. Information Systems will deliver weekly to each agency the placement file, containing patient demographic, insurance, documentation and charge data. Information Systems will provide placement information including the number of accounts and total dollar amount placed to the Collection Liaison.**
- I. Agency will load placement and send hospital an acknowledgement, validating receipt of placement.**
- J. Hospital Collections Liaison will reconcile placement information against acknowledgement and resolve variances. Variances remaining unresolved more than one business day will be reported to Manager, Billing Operations and Director PFS.**
- K. Agency initiates defined workflow process, to include outbound telephone calls and mailing statement/invoices to guarantor.**
- L. Bad Debt agency attempts to –**
 - develop insurance information not provided at time of registration
 - obtain payment in full
 - establish acceptable payment plan
 - investigate guarantor's ability to pay based on income/assets/ employment status, and make financial assistance referral as appropriate (refer to in-house Medical Assistance Eligibility department or send Financial Assistance application and make referral to hospital)
 - determine if account is of legal merit (guarantor has assets or patient is employed)

- M. If successful, the agency will hold the account until it is resolved.**
- N. If unsuccessful after approximately 180 days, agency prepares a close file on a monthly basis for return to the hospital.**
- O. Closed files are received by hospital Information Systems based on specific criteria and out-for-collection codes are updated to reflect the new assignment to the second agency and placed with the second agency on a monthly basis. Information Systems provides second placement information to hospital Collections Liaison.**
- P. Agency loads second placement and sends hospital an acknowledgement, validating receipt of placement.**
- Q. Hospital Collections Liaison reconciles placement data against acknowledgement and resolves variances. Variances remaining unresolved more than one business day will be reported to Manager, Billing Operations and Director PFS.**
- R. Agency initiates defined second placement workflow process, to include outbound telephone calls and mailing statement/notices to guarantor.**
- S. Agency retains account for period of three years from date of service or until the statute of limitations has expired (whichever is greater). Accounts exceeding the legal statute of limitations are closed and returned to hospital.**
- T. Sinai Hospital shall not report, for at least 120 days after issuing an initial patient bill, adverse information about a patient to a consumer reporting agency or commence civil action against a patient for nonpayment unless the hospital documents the lack of cooperation of the patient or the guarantor of the patient in providing information needed to determine the patient's obligation with regard to the hospital bill.**
- U. Sinai Hospital shall report the fulfillment of a patient's payment obligation within 60 days after the obligation is fulfilled to any consumer reporting agency to which the hospital had reported adverse information about the patient.**
- V. If the hospital has obtained a judgment against or reported adverse information to a consumer reporting agency about a patient who later was found to be eligible for free care on the date of the service for which the judgment was awarded or the adverse information was reported, the hospital shall seek to vacate the judgment or strike the adverse information.**

IV. Collection Accounts Referred to Agency Legal Department

Policy: It is the policy of Sinai Hospital to utilize legal remedies (lawsuits) to assist in the recovery of outstanding patient account balances only as a last resort. All efforts to secure a reasonable payment plan are exhausted prior to taking legal action to obtain a judgment. During this process, every effort is made to ensure patients are treated fairly, with dignity, compassion and respect. Sinai Hospital will not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill. If Sinai holds a lien on a patient's primary residence, it may maintain its position as a secured creditor with respect to other creditors to whom the patient may owe a debt. Note: Baltimore City judgments result in "automatic" liens being placed on patient/guarantor's real property. However, this does not prevent the Hospital from forcing the sale of a secondary property or residence owned by the patient or guarantor. As a rule, Sinai instructs its collection agents to not pursue post-judgment liens on real property in any other jurisdiction.

- A. Based on agency's verification of guarantor income/assets/employment status, an account may be referred to that agency's legal department for review.**
- B. Agency is required to have completed call and letter process without resolution of the balance.**

- C. Accounts are referred to the agency's attorney for review to insure that filing suit is appropriate.
- D. Letter is sent to the guarantor from the law firm. Guarantor has thirty days to dispute the debt. Agency will provide verification of debt upon request
- E. Law firm will generally attempt to reach guarantor by phone before sending affidavit to Sinai Hospital
- F. Affidavit (Attachment #4), including documentation to support law firm's verification of guarantor's income/assets and/or employment status, is sent to the hospital for review and authorization to proceed.

- G. Collection Liaison reviews all affidavits prior to approval for suit
 - accounts are noted in MPAC with specific reason case qualifies (asset - owns home, employed, etc.)
 - Collection Liaison signs and dates affidavit
 - additional signatures are required for amounts greater than \$4,999.99 using Legal Authorization Form (Attachment #5):
 - \$ 5,000.00 - \$ 9,999.99 Manager, Billing Operations
 - \$10,000.00 - \$24,999.99 Director, PFS
 - \$25,000.00 + V.P. Revenue Cycle
 - signed affidavits are returned to the legal department of the agency
 - upon return of the signed affidavit to the agency, suit is filed with the appropriate court jurisdiction
- H. If guarantor files motion to defend, a merit trial is scheduled at the appropriate district court.
 - a designated hospital representative attends, prepared to testify at the merit trial
- I. Judgment is awarded to Sinai Hospital unless the guarantor is able to prove to the satisfaction of the court that the balance is not owed (in which case the guarantor is exonerated from owing the debt). Judgment is automatically reported on the guarantor's credit report by the court system because the judgment is now a public record. Guarantor has every opportunity to challenge the suit in court, however, if they fail to appear judgment by default is generally awarded.
- J. Guarantor has 45 days after judgment is entered in which to file an appeal. If guarantor files an appeal within 45 days, the court process starts over.
- K. Legal department of agency makes additional contact attempts (phone) to guarantor to resolve debt prior to garnishment of wages.
- L. If guarantor fails to file an appeal and has not responded to attempts to settle the judgment prior to garnishment
 - agency files garnishment, which is sent to guarantor's employer
 - agency confirms that employer attaches garnishment to guarantor's wages
 - if guarantor is no longer working at employer on file, agency seeks new employment information, real property to file a lien against, or bank accounts to attach
- M. Where appropriate, in cases when a guarantor has expired and has verifiable assets, a claim against the estate is filed.
- N. Guarantor is assessed post-judgment interest, which is determined by Maryland State law. Additionally, the guarantor must also pay expended court costs. Sinai is prohibited from charging prejudgment interest.
- O. Select Motor Vehicle Accident (MVA), Workman's Compensation, and other Third Party Liability referrals may be placed with an agency as active AR, then manually transferred to bad debt once the account reaches approximately 150 days for MVA and approximately 90 days for Workman's Compensation.

- agency sends letter to guarantor's attorney requesting PIP and health insurance information and liability information
- if all are provided, agency will accept a letter of protection for up to six months
- if resolution is not obtained within six months, agency sends a letter of intent to file suit to guarantor's attorney
- under some circumstances, agency will extend protected period beyond six months
- agency provides guarantor's attorney with copies of bills if requested
- agency files suit as a means to pressure guarantor's attorney to expedite settlement
- legal process follows steps outlined above (H – L)

V. Credit Reporting

- A. A patient debt may be reported to a credit reporting agency after judgment is obtained and becomes public record.**
- B. Accounts referred for secondary collections placement may be reported provided at least 120 days have lapsed after the initial patient bill is issued.**
- C. Agency and/or agency attorneys shall report to any consumer reporting agency the fulfillment of a patient payment obligation within 60 days after the obligation has been fulfilled.**
- D. Agency must maintain documentation ensuring compliance with the 60-day rule.**

VI. Related Collections/Bad Debt Documentation

- A. Bad Debt Payments/Adjustments**
 - bad debt recoveries can be paid directly to Sinai Hospital or can be paid to the designated agency
 - recoveries that are paid directly to the hospital are posted to the appropriate account and reported to the collection agency via Information Systems generated electronic file on a daily or weekly basis
 - recoveries that are paid directly to the collection agency are reported to Sinai Hospital electronically on a weekly basis. 100% of payment is forwarded to the hospital with the monthly invoice. Fees are not netted from invoiced recoveries
 - non-payment transaction codes (adjustments) are reported to the appropriate agency as non-payment activity (commission is not paid for non-payment transactions)
 - agencies are only entitled to take commission for payment transaction codes. Agencies are responsible for processing all other non-commission transaction codes for the sole purpose of maintaining accurate patient account balances
- B. Patient Refunds**
 - Effective with dates of service October 1, 2010, Sinai Hospital shall provide for a full refund of amounts exceeding \$25 in total, collected from a patient or the guarantor of a patient who, within a 2-year period after the date of service, was found to be eligible for free care on the date of service.
 - The hospital may reduce the 2-year period to no less than 30 days after the date the hospital requests information from a patient, or the guarantor of a patient, to determine the patient's eligibility for free care at the time of service, if the hospital documents the lack of cooperation

of the patient or the guarantor of a patient in providing the required information.

- If the patient or the guarantor of the patient has entered into a payment contract, it is the responsibility of the patient or guarantor of the patient to notify the hospital of material changes in financial status, which could impact the ability to honor the payment contract and qualify the patient for Financial Assistance.
- The Hospital must refund amounts paid back-dated to the date of the financial status change, or the date the financial status change was made known to the Hospital, which is most favorable for the patient. Previous amounts paid in accordance with a payment contract will not be considered refundable.

C. Bad Debt Authorization Form – Required Authorizations By Balance Range

- Bad Debt Authorization Form (Attachment #2) is a tool utilized to ensure that patient accounts meet the criteria required to be considered uncollectible and that appropriate authorizations are obtained. It is not used for balances less than \$5,000.00 when the procedures outlined in this policy have been followed. Collector notes must thoroughly document all steps outlined within this policy have been taken
- signatures are required for amounts greater than \$4,999.99
 - \$ 5,000.00 - \$ 9,999.99 Manager, Billing Operations
 - \$10,000.00 - \$24,999.99 Director, PFS
 - \$25,000.00 + V.P. Revenue Cycle

D. Collection Agency Invoices

- agencies will invoice Sinai Hospital on a monthly basis not to exceed the eighth day of the month
- invoice will consist of a detailed accounting of each payment transaction and include at a minimum the following information:
 1. client code
 2. patient account number
 3. patient name
 4. transaction type (debit or credit)
 5. amount paid
 6. commission due for each payment
 7. current account balance
 8. invoice total dollars paid
 9. invoice total commission due
- Collection Liaison is responsible for auditing all agency invoices for accuracy. Invoices are audited primarily for the following:
 1. to ensure contingency fees (commission) are calculated properly
 2. to ensure duplicate payments are not reported (same or previous invoice)
 3. to ensure payments are not reported for accounts that have been recalled or in a 'closed and returned' status
- Collection Liaison is responsible for maintaining a spreadsheet for each agency, documenting audit findings and resolution. Collection Liaison contacts the agency to settle any discrepancies and secures a corrected invoice if needed. Invoices are coded and appropriate authorization signature is obtained.
- all invoices require Director, PFS or designee authorization before sending to Accounts Payable for processing
- Collection Liaison reviews audit results with Manager – Billing Operations monthly to ensure accuracy of the audit and expense

process. Manager – Billing Operations reports findings to Director, PFS on a monthly basis

E. Estimates, Telephone Inquiries, Disputes and Correspondence

- written estimates are provided on request from an active or scheduled patient made before or during treatment. The Hospital is not required to provide written estimates to individuals shopping for services. The Hospital shall provide to the patient a written estimate of the total charges for the hospital services, procedures, and supplies that are reasonably expected to be provided and billed to the patient by the hospital. The written estimate shall state clearly that it is only an estimate and actual charges could vary. The hospital may restrict the availability of a written estimate to normal business office hours. The Director of Patient Access and/or designee shall be responsible for providing all estimates (verbal and written). Patient requests for estimates, whether received by Patient Financial Services or an agency, should be forwarded to the Director, Patient Access or designee.
- Patient Financial Services Customer Service Department is responsible for telephone inquiries received by the call center during published hours of operations. Voicemail is available for patients to leave a message after hours. Customer Service will respond to all inquiries on accounts not placed with an agency.
- patient inquiries on accounts placed with an agency, where it is determined that a complaint or dispute does not exist, are referred to the appropriate collection agency for handling. It is standard practice not to intervene and set patient payment arrangements when an account has been placed with a collection agency.
- disputes received by the hospital are handled in accordance with the Fair Credit Billing Act, requiring the hospital to respond within thirty days of receipt. If a billing error is identified, the appropriate corrections must be made to the account within the same thirty-day period.
- disputes received by an agency are handled in accordance with the Fair Credit Billing Act, requiring the agency to respond within thirty days. The agency will coordinate with the hospital and provide to the patient any information required validating the service and/or correcting a billing error within the thirty-day response timeframe.
- correspondence received will be documented in the system and a photocopy forwarded to the agency. Priority correspondence may be communicated to the agency via email as well. The original document will be retained in Patient Financial Services Department.

F. Patient Complaints

Complaints against the hospital:

- all hospital complaints are referred to the Director, Patient Financial Services or designee for investigation and resolution

Complaints against collection agencies:

- all collection agency related complaints are referred to the Collection Liaison
- the agency is contacted and apprised of the complaint. The agency is given the opportunity to promptly research and respond. The agency is advised that all collection activity on the account is suspended until further notice
- based on the agency's response, the Director, PFS or designee will determine if the complaint is founded or unfounded
- if unfounded, the Collection Liaison will advise the patient that the complaint was investigated and the agency's handling of the account was appropriate. The patient is then instructed to contact the agency to

- establish payment arrangements. The agency is updated and given permission to resume collection activity
- if founded, based on the severity of the complaint, one or more of the following actions will occur:
 1. 'close and return' the account immediately
 2. terminate or suspend contract with collection agency based on previous complaint history
 3. request that the complaint generating collector no longer handle Sinai Hospital and/or LifeBridge Health accounts
 4. request that the agency's operations manager contact the patient and personally handle the account
- G. Recalling Accounts From Collection Agencies**
- Collection Liaison or designee will contact the agency via email or telephone to initiate the recall process
 - agency representative is informed of the reason for the recall. System is documented with the agency representative's name and pertinent collection notes
 - when appropriate, the account is reactivated in system to the active receivable. In some cases, changing the out-for-collection code to an internal bad debt code is sufficient
- H. Settlements**
- agencies will occasionally identify accounts for which a settlement is the best collection opportunity
 - typically, accounts that fall into this category involve insurance settlement or lump sum proceeds from asset sales
 - Director, PFS must approve all settlements
- I. Auditing Collection Agencies**
- it is Sinai Hospital's standard practice to audit collection agencies on a routine basis. The Director, PFS or Manager – Billing Operations, Collection Liaison and/or designee, performs audits at intervals not to exceed twelve months. Audits will be performed sooner if there is reason to believe an audit is warranted. The primary purpose of the audit is to ensure that the collection agency is operating and performing consistently with the conditions and stipulations outlined in the collection contract. This includes, but is not limited to ensuring that the collection agency is complying with the following:
 1. consistent and timely receipt of referred accounts in Sinai Hospital's system format
 2. consistent and timely production of acknowledgement report for referred accounts within forty-eight hours of placement
 3. consistent and timely 'close and return' of accounts when specified criteria is met
 4. consistent and timely submission of invoices for commissions earned
 5. providing other reports as requested
 - in addition, it is also standard practice to select (at random) a sample of at least twenty referred accounts in order to review the agency's collection work activity. The primary purpose of the account review process is to ensure that Sinai Hospital's accounts are worked consistently and thoroughly
 - upon completion of the audit, an exit meeting is held with the agency's management team to discuss areas of concern and their corrective action plans. The Manager – Billing Operations and/or designee, summarizing the various components of the audit; providing additional details for areas of concern and corrective action plans, completes an Audit Findings Report (Attachment #3). If the audit findings raise

serious concerns about the collection agency, the Director, PFS will immediately advise the Vice President of Revenue Cycle to discuss recommendations on how to proceed

- J. Bad Debt Performance Analysis**
 - utilized to track agency performance on a comparison basis and calculate gross/net recovery percentages. Agency performance analysis reports are forwarded to Director, PFS and V.P. Revenue Cycle by the 15th of each month
- K. Active Accounts Receivable Placements**
 - Periodically, accounts on the active insurance receivable may be selected for insurance outsource placement as requested by the Director, PFS. Agencies receive placements electronically
- L. Second Placements**
 - accounts that have not rendered a payment arrangement, uncovered active insurance or have not gone to the legal department of the primary placement agency within approximately 180 days of the primary placement date are closed and returned by the primary agency for second placement
 - electronic files are sent from the primary agency to Sinai Hospital Information Systems
 - Information Systems updates the bad debt assignment code along with verbiage to reflect the reason for close and return; as well as documentation noting the referral to the second placement agency
 - 'close and returns' reasons listed below (if known) from primary agency that are generally not second placed include:
 1. destitute – the debtor's income, if any, is derived from public sources such as SSI or welfare, and the debtor lacks other resources to pay
 2. bankrupt – the debtor has filed a petition of bankruptcy
 3. incarcerated – the debtor is incarcerated
 4. deceased – the debtor has died and an investigation for estate assets has not revealed results
 5. low income – the income and family size put the debtor below 200% of the HHS poverty guidelines
 6. no assets – the debtor has no known property, job or other items considered of value for legal attachment
 7. eligible for non-reimbursable Medical Assistance program/s – the debtor is eligible for state assistance that does not reimburse hospital expenses, such as PAC, Family Planning, Pharmacy Only, etc.
 8. border states – where agency is not licensed to collect
 9. insurance issues – where debtor is deemed by the insurance carrier to be held harmless
- M. Small Balance Write-Off/Adjustment**
 - patient balance less than \$10.00 is adjusted to zero using the appropriate small balance CDM. This process occurs automatically on a weekly cycle
 - end-of-month report is compiled by Collection Liaison and patient balance less than \$10.00 is adjusted to zero using the appropriate small balance CDM. This process is manual and occurs on the last business day of the month
- N. Bad Debt – Internal Write-off**

- based on established criteria, accounts identified for bad debt – internal write-off are transferred to designated out-for-collection codes, which continue to be managed by PFS Department
 - Medicaid Pending accounts are transferred to internal bad debt while assigned to internal or external MA Liaison/MA Eligibility Agencies while the application process is taking place. Transfers to internal bad debt can occur both manually and systematically once the account reaches 100% reserve status. This can occur without an approved Bad Debt Authorization Form, since the account is not being referred for collection
- O. Bad Debt Reactivation
- accounts transferred to bad debt may be reactivated to the active receivable
 - Medicaid Pending accounts transferred to internal bad debt during the application process must be reactivated from bad debt once Medicaid eligibility is determined

DOCUMENTATION/APPENDICES:

Attachment #1 Self Pay Checklist immediately follows policy

Attachment #2 Bad Debt Authorization Form is a separate excel format file

Attachment #3 Audit Findings Report is a separate excel format file

Attachment #4 Affidavit is a separate word document file

Attachment #5 Legal Authorization Form is a separate excel format file

STATEMENT OF COLLABORATION:

Director, Patient Access

SOURCES:

Health Services Cost Review Commission

Debt Collection Policy

- effective December 01, 2008

Self Pay Checklist

Patient Name: _____
Account# _____
Admit Date _____ Today's Date: _____

Before contact with patient-Initial each step

Check ALL prior registrations

Check HDX

Check MA

Check Medicare (if patient is over 65 years)

Other automated Websites checked: _____

Update insurance with appropriate financial class.

Interview Patient (phone or face-to-face)

Are you insured? _____

Are you employed?

Income: \$ _____ Year _____ Week _____

Household size _____ Verify annualized income against F.A poverty guidelines.

Does patient have ability to pay? YES ___ NO ___

Payment: _____ Payment arrangement established: _____

Continuation of Interview for MA: Indicate YES ___ or NO ___

Patient has Medicare? YES ___ NO ___

Patient over age 65? YES ___ NO ___

Patient under 21? YES ___ NO ___

Patient is currently pregnant? YES ___ NO ___

Patient has child or children who are under age 21 residing with patient? YES/NO

Patient is blind? YES ___ NO ___

Patient has Aids or is HIV+? YES ___ NO ___

Patient is disabled? YES ___ NO ___ Disabling Condition _____
(Note: Pt needs to be unable to work for 12 months)

Patient had MA in past? _____ If so, when _____

MA Application under consideration? YES ___ NO ___