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Approvals:

Board of Directors Approval 01/20/2020
Date

Anthony K. Morris _____ 2/4/2020
Senior Vice President
Chief Revenue Officer **Date**

Maggie Morgan-Lamb Maggie Morgan-Lamb 2/4/2020
Director, Patient Financial Services **Date**

LEVINDALE HEBREW GERIATRIC CENTER
POLICIES AND PROCEDURE MANUAL

POLICY/PROCEDURE NUMBER:	**7.0**
POLICY/PROCEDURE NAME:	**Collections**
APPROVED BY:	**Maggie Morgan**
EFFECTIVE DATE:	**July 99**
REVISION DATE:	**January 03**
REVISION DATE:	**December 05**
REVISION DATE	**November 07**
REVISION DATE:	**January 08**
REVISION DATE	**October 2010**
REVISION DATE	**June 1, 2014**
REVISION DATE	**August 2018**

RESPONSIBLE PARTY:

The Patient Financial Services Department

PURPOSE: Levindale Hebrew Geriatric Center and 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.

Levindale Hebrew Geriatric Center and Hospital contracts with third party receivables management agencies to provide extended business office services for insurance outsource services to ensure maximum effort is taken to recover insurance receivables prior to transfer to bad debt. This collection agencies must operate consistent with Levindale'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. Levindale and its agents shall assist uninsured and underinsured patients and eligible family members with the Financial Assistance application process in accordance with hospital policy. Levindale 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, Levindale is prohibited from selling any debt.

POLICY: It is the policy of Levindale Hebrew Geriatric Center and Hospital is 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 to bad debt accounts when they have met 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.

Procedure:

I. Early-Out Self-Pay (EOS) – Hospital outpatient and inpatient

A. Financial Counselor reviews all inpatient admissions to ensure that Insurance coverage has been verified and accurate. FC screens for the out of pockets expense that are known on admission, and will refer the case to the Medicaid Coordinator to screen for Medicaid eligibility.
B. The Outpatient registration clerks review all Insurance coverage for coverage and Patient out of pocket expense. She will refer the case to Medicaid outsource vendor when appropriate
C. Once Medicaid screening are completed the Revenue Cycle is updated with Pending Medicaid Insurance remains Self Pay.
D. Revenue Cycle query file is run monthly and contains all self-pay balances, patient demographic, insurance, documentation and charge data at a point in time.
E. The Director of PFS reviews charge file with Vendor's inventory to identify new accounts.
F. Spreadsheet is modified to list only new accounts being referred. Spreadsheet is placed in vendors portal.
G. Vendor will load the spreadsheet into their data base.
H. 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.
I. EOS vendor initiates defined workflow process, to include outbound telephone calls and mailing statement/invoices to guarantor.
J. 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 offer Financial Assistance referral as appropriate (refer to in-house Medical Assistance Eligibility department or send Financial Assistance application and make referral to hospital)
K. If successful, the EOS vendor will hold the account until it is resolved.
L. If unsuccessful and after some period of time, EOS vendor will reach out to Director of PFS and discuss transition accounts to internal bad debt workflow process. Note: The vendor's classification of active AR or bad debt does not affect the hospital's classification of the account.
M. If unsuccessful, EOS vendor prepares a close file monthly for return to the hospital.
N. Closed files are sent to Director of PFS for review and next steps which may include Bad Debt and write off the AR
O. Levindale will provide active oversight of any contract for collection of debts on behalf of the hospital.

II. Nursing Home

A. Financial Counselor reviews all inpatient admissions to ensure that Insurance coverage has been verified and accurate. FC screens for the out of pockets expense that are known on admission, and will refer the case to the Medicaid Coordinator.
B. Medicaid Coordinator will contact Patient/RP to determine if patient is eligible for Medicaid Benefits and if so assist in making application for LTC Medicaid.

C. If the patient is not eligible for Medicaid but unable to pay privately, the Collections Coordinator would complete a Financial Assistance application with the patient/RP. (See Financial Assistance Policy)
D. If the patient is not eligible for Medicaid or Financial Assistance then the account is set to print statements monthly for Patient Liability after Ins and set up for Advance Monthly billing if Self-pay for Room and Board.
E. Collections Coordinator will monitor spend-down of Self-pay for Room and Board accounts and coordinate with Medicaid Coordinator when the patient is eligible.
F. Collections Coordinator will monitor all Nursing Home account meet compliance based on the terms of the State Approved Admissions Contract. Meetings are conducted monthly with Administrator, Social Work, DOB, Guest Relations and PFS to discuss non-compliant accounts next steps which could include 30-day Discharge Notice for Non-payment.
G. Account balances will be adjusted in accordance with the Financial Assistance policy/procedure. If ineligible, due to over-scale income or uncooperative with the Medicaid process patient will be reviewed for Bad Debt Write off by the Director of Patient Financial Services.

III. Adult Daycare and Outpatient Rehabilitation

A. Registration in these areas will collect and verify all Insurance coverage prior to scheduling their services.
B. Patients that have out of pocket will discuss the terms with the Patient/RP
C. Collections Coordinator will provide bills monthly and monitor for payments. Accounts that become delinquent will be referred to the Manager of the Outpatient Areas.
D. Account balances will be adjusted in accordance with the Financial Assistance Policy and Procedure. If ineligible patient will be reviewed for Bad Debt Write off by the Director of Patient Financial Services.

IV. Collection Accounts Referred to Agency Legal Department – Nursing Home Only

Policy: It is the policy of Levindale Hebrew Geriatric Center and 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. Levindale will not force the sale or foreclosure of a patient's primary residence to collect a debt owed on a hospital bill. If Levindale 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 Facility from forcing the sale of a secondary property or residence owned by the patient or guarantor. As a rule, Levindale instructs Legal agents to not pursue post-judgment liens on real property in any other jurisdiction.

A. Based on the facilities verification of patient income/assets/employment status, an account may be referred to that Legal department for review.
B. Legal Authorization Form (Attachment 3) is completed by Medicaid Coordinator or Collections Coordinator for PFS Director authorization to proceed with sending letter of resolution to the Patient/RP which may include court proceedings.

C. Attorney will send a letter to identify the actions available to resolve the outstanding balance. Payment in full or payment plan. Cooperate with application for Medicaid Benefits.
D. Guarantor has thirty days to dispute the debt.
E. If unsuccessful the facility will contact Law firm to apply for Guardian of Property

V. Credit Reporting

A. A patient debt may be reported to a credit reporting agency after judgment is obtained and becomes public record.
B. 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.

VI. Related Collections/Bad Debt Documentation

A. Bad Debt Payments/Adjustments
- Payments received for DOS 270+ days will be entered as Bad Debt recoveries.
- Adjustments for DOS 270+ will be entered as over 270 BD code Bad Debt Authorization Form (Attachment 1)

B. Patient Refunds
- Effective with dates of service October 1, 2010, Levindale shall provide 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.
- Bad Debt Authorization Form – Required Authorizations 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. Collector notes and all documentation related to the case must be provided
- signatures are required for amounts greater than $4,999.99

$0.00 - $24,999.99	Director, PFS
$25,000.00 +	Senior V.P. and Chief Revenue Officer

C. Collection Agency Invoices
- agencies will invoice monthly, 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

- Director of PFS reviews the Invoice 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
- all invoices are coded with blanket PO and signature require Director, PFS before sending to Accounts Payable for processing

- 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 hours of operations are Monday through Friday 9-5. Voicemail is available for patients to leave a message after hours. Customer Service will respond to all within 24 hours
  - 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.
- Patient Complaints

  Complaints against the hospital:
  - all hospital complaints are referred to the Director, Patient Financial Service

  Complaints against collection agencies:
  - all collection agency related complaints are referred to the Director of Patient Financial Services

- 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 of PFS will determine if the complaint is founded or unfounded
- if unfounded, the Director of PFS 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

- Recalling Accounts from Collection Agencies
    - Director of PFS 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
- 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
- Auditing Collection Agencies
    - it is Levindale Hospital's standard practice to audit collection agencies on a routine basis. The Assistant Director, PFS 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. Appropriate collection efforts are being performed
        2. consistent and timely 'close and return' of accounts when specified criteria is met
        3. providing other reports as requested
    - If upon completion of the audit, there are areas of concern an exit meeting is held with the agency's management team and their corrective action plans. The Assistant Director, PFS completes an Audit Findings Report (Attachment #2). 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
- Insurance Accounts Receivable Placements
    a. Periodically and at 240 days, accounts with active insurance receivable may be selected for insurance outsource placement as requested by the Assistant Director, PFS.

- accounts that have not rendered a payment arrangement or continue to delivery false denial statements, are referred to an outside Collection Agency. Insurance claims are subject to review and the patient is held harmless
    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

- Small Balance Write-Off/Adjustment
    - patient balance less than $25.00 is adjusted to zero using the appropriate small balance CDM. At the end-of-month patient balance less than $25.00 is adjusted to zero using the Small Balance Program.

DOCUMENTATION/APPENDICES:
Attachment #1 Bad Debt Authorization Form is a separate excel format file
Attachment #2 Audit Findings Report is a separate excel format file
Attachment #3 Legal Authorization Form is a separate excel format file

STATEMENT OF COLLABORATION:
Registration departments at Levindale

SOURCES:
Health Services Cost Review Commission