FINANCIAL POLICY

DEFINITION AND PURPOSE:

The purpose of this policy is to define the multiple policies and procedures that work together to protect the organization's financial security and thus further the mission of Enloe Health to provide cost effective healthcare for the people in the communities we serve.

DEFINITIONS:

The following are admission types as defined by billing regulations:

Elective: The patient's condition permits time for services to be scheduled and authorized prior to the scheduling of those services.

Urgent: The patient requires timely attention for care and treatment of a physical or mental disorder; typically, within one week.

Emergent: The patient requires immediate medical intervention due to severe life-threatening or potentially disabling condition.

POLICY: ELECTIVE SERVICES

It is the policy of Enloe Health to financially secure through obtaining authorizations or collecting patient deposits for elective services prior to the scheduling of those services. This includes nonemergent hospital transfers. Exceptions must be approved as follows:

- Since Enloe contracts with several health plans, it does not routinely contract for individual case rates with non-contracted health plans. Any exceptions to this policy must be approved prior to scheduling by the Manager of Patient Financial Services (PFS Manager), Director of Patient Financial Services (PFS Director), Senior Director of Revenue Cycle Operations & Technology (Sr. Director of Rev. Cycle Ops. & Tech), or Chief Financial Officer (CFO).

- The PFS Manager, PFS Director, Sr. Director of Rev. Cycle Ops. & Tech., or CFO are authorized to approve transfers to inpatient Rehabilitation prior to funding sources being secured if, in their opinion, it is likely that eligibility will be granted, and/or it is not safe to discharge patient to home.

- The Financial Counselor is authorized to approve a payment plan up to three months if a patient is unable to pay the estimated out-of-pocket expense before or at the time of admission. The patient must be able to demonstrate the ability to maintain the payment plan.

- The PFS Manager, PFS Director, Sr. Director of Rev. Cycle Ops. & Tech., or CFO must approve payment plans beyond three months for all elective services.

- The Vice President of Patient Care Services, CFO, and Chief Executive Officer (CEO) may authorize exceptions not approved by the Sr. Director of Rev. Cycle Ops. & Tech.

PROCEDURE: ELECTIVE SERVICES

- For Hospital and Surgical services, the Pre-Registration and Authorization staff will verify insurance benefits and screen all payer sources to ensure that payer requirements have been met and authorization was obtained.
    - If applicable, transferring hospitals are required to provide current insurance benefits and a face sheet that provides the necessary demographic information.
- For ancillary services, it is the responsibility of the department scheduling the services (i.e., Radiology, Cardiology) to determine if authorization is required and has been obtained by the scheduling physician's office prior to the patient being scheduled or presenting for services.
    - If services are scheduled without an authorization, Pre-Registration will contact the physician's office for status. The physician will be asked to reschedule the patient if authorization will not be received by date of service.
    - The account will be escalated to the Director of Patient Access (Access Director), PFS Director, or Sr. Director of Rev. Cycle Ops. & Tech. if the physician's office is not cooperative.
- The Financial Counselor will calculate the patient's expected out-of-pocket expenses and will request payment for that amount prior to or at check-in on the date of service.
    - Self-pay discounts will be offered to uninsured patients in accordance with the organization's Community Service and Discount Policy.
    - The Financial Counselor is authorized to establish a payment plan that does not exceed 90 days if the patient has a good payment history and is able to pay 50 percent of the expected out-of-pocket expenses at the time of service.

      Note: For bariatric patients, the Financial Counselor is responsible for accepting a deposit of one-third of the patient's out of-pocket expenses and establishing a payment plan on the remaining balance of three equal monthly payments if the patient's financial information supports the ability to keep the payment plan.
    - The Financial Counselor will contact the physician's office to reschedule the patient when a scheduled patient's account cannot be financially secured.
    - Exceptions to policy may be approved for scheduled non-urgent services, as noted above.
- The Financial Counselor will *request* payment of any bad debt accounts prior to scheduled services; however, prior bad debts will not prohibit future services if those

services have been financially secured.

- At check-in, Admitting and Registration is responsible for collecting co-pays per agreements made with the Financial Counselor.

POLICY: URGENT SERVICES

It is the policy of Enloe Health to financially secure scheduled urgent services prior to a patient's arrival. However, exceptions will be approved based on medical necessity provided by the physician's office. Urgent services can be defined, but not limited to, cardiac surgery, chemotherapy, biopsies and additional follow-up treatment, or surgery originally performed at Enloe.

PROCEDURE: URGENT SERVICES

- The Financial Counselor is authorized to approve a payment plan up to three months if patient is unable to pay estimated out-of-pocket expenses before or at the time of admission. Patient must be able to demonstrate the ability to keep the payment plan.
    - The financial counselor will assist the patient, as needed, with other funding sources.
    - The financial counselor will contact the physician's office to discuss rescheduling the patient when a scheduled patient cannot be financially secured. It is never the intent of Enloe Health to delay, defer, or deny emergent and/or medically necessary care. Please see hospital's Management of Individuals Presenting for Emergency Care Policy.
    - The financial counselor will escalate the account to the Access Director, PFS Director, or Sr. Director of Rev. Cycle Ops. & Tech. when the physician's office validates the medical necessity or urgency for the treatment.
    - The PFS Manager, PFS Director, or Sr. Director of Rev. Cycle Ops. & Tech. must approve payment plans beyond three months for all scheduled urgent services.
    - The PFS Director, or Sr. Director of Rev. Cycle Ops. & Tech. is authorized to approve free or discounted care for urgent services in accordance with the Community Service and Discount Policy.

POLICY: EMERGENT SERVICES

It is the policy of Enloe Health to comply with all state and federal regulations regardless of a patient's ability to pay.

> **Note:** During a mental health assessment, a patient that has been deemed to be a danger to him or herself will fall under the emergency status.

Once a patient's emergency condition is stable, it is the policy of the organization to follow state and payer guidelines.

PROCEDURE: EMERGENT SERVICES

- Emergency Room:
    - After an emergency room patient has been triaged, and the patient's medical record number has been identified, registration will verify the last insurance on file and complete as much prep work as possible before meeting with the patient or guarantor.
        - Once registration is cleared by Emergency Room staff to meet with patient, Registration will request a copy of the insurance card or update demographic information as needed to financially secure the account.
        - Registration will request co-pays and deductibles from insured patients prior to or at discharge.
        - Uninsured patients will be given applications to Medi-Cal, Covered California, and a plain language summary of Enloe Health's Community Service and Discount programs as mandated by state and federal regulations. Registration staff will review the material with the patient or family as time allows.
    - ER staff are responsible for escorting discharged outpatients to Registration to complete securing the account.
    - Registration staff will request payment on any bad debt accounts and refer patients to Patient Financial Services, if appropriate.
- Emergency Room Admits and Direct Physician Admissions:
    - Patients who are admitted prior to Registration securing the account will be flagged for need of completion.
        - When registration cannot be completed in the ER, the Admitting Representative will complete registration bedside at the first available opportunity.
        - The House Supervisor is responsible for alerting Admitting of direct admits called in by a physician's office. The Admitting Representative will complete registration bedside at the first available opportunity.
        - Insurance and other demographic information that will be updated are including, but not limited to, next of kin, person to notify, and patient address. Employment information, including spouse, will be updated on all uninsured patients as well as patients with non-government insurances.

- Patients with limited or no insurance will be referred to a Financial Counselor. Limited insurance includes, but is not limited to, high out of pocket medical expenses, any insurance that pays a per diem rate, limits inpatient payment to room and board only, deductibles that exceed $3,500, or the patient co-pay exceeds 20 percent.

- Financial Counselors will explore available funding sources including internal and external assistance programs to assist patient as needed to secure the account prior to discharge.

- The Insurance Verifier will notify the insurance plan, as required, of patient's admission to ensure authorization of medically necessary care and provide the opportunity for Case Management review and discharge planning.

POLICY: CONTINUED INPATIENT STAYS

It is the policy of Enloe Health to track inpatient stays to ensure continued financial security. Financial counseling services are available as needed.

PROCEDURE: CONTINUED INPATIENT STAYS

- In accordance with current departmental procedures, Patient Access will verify insurance benefits at the beginning of each calendar month to ensure continued coverage.

- Designated staff will alert a Financial Counselor when benefits are at risk of exhaustion.

- The Financial Counselor will alert Case Management and will obtain the required Medicare form when a Medicare patient goes into lifetime reserve days.

- The Financial Counselor will assist patient, as needed, to secure funding.

- The Financial Counselor will work with the Insurance Verifier to obtain authorization and/or benefits from any supplemental insurance, including Medi-Cal.

- The Financial Counselor will seek assistance from available contracted vendors in accordance with departmental guidelines to convert patients to full scope Medi-Cal for transfer to a lower level of care.

- Case Management will provide a concurrent review, in accordance with their department policies, to ensure care is medically necessary and patient's insurance plan continues to authorize the stay.
  - Case Management will involve a financial counselor when a patient refuses discharge~~,~~ transfer, or fails to comply with insurance requirements that could result in denied days.

- Case Management and Financial Counseling will work together in providing the non-certification letter to the patient or family. The Financial Counselor is responsible for explaining financial liability and requesting payment.

POLICY: CLINIC SERVICES

It is the policy of Enloe Health to financially secure through obtaining authorization and collecting patient deposits for clinic visits prior to the scheduling of those services.

PROCEDURE: CLINIC SERVICES

- Prompt Care patients who arrive in distress will be referred to clinical staff in accordance with department guidelines.

- Non-emergent patients will be fully registered prior to being seen.

  - Registration will request co-pays and deductibles from insured patients.

  - Registration will flag non-contracted or HMO (health management organization) patients to clinical staff.

  - Registration will provide uninsured patients applications to Medi-Cal, Covered California, and a plain language summary of Enloe Health's Community Service and Discount programs as mandated by state and federal regulations.

- Registration staff will request payment on any bad debt accounts and refer patients to Patient Financial Services, if appropriate.

- It is the responsibility of the clinics to obtain authorization for a patient referred to the hospital for diagnostic testing.

PATIENT FINANCIAL SERVICES POLICIES

PAYMENT PLANS:

- Interest-free payment plans up to six months, may be approved by Customer Service. These accounts will be retained on the hospital's accounts receivable.
- Payment plans that will take seven to 48 months will be considered long term and assigned to an outside agency to charge six percent interest unless the patient has qualified for partial community service with an FPL < 400% then no interest is assessed. The long-term accounts receivable will be reported internally as an outsource agency and no adverse credit reporting or extraordinary collections actions (ECA's) will be used in collection of this debt.

  - Patients who break their payment plan for 90 consecutive days will be considered delinquent and the payment plan will be considered inoperative. The remaining debt may be referred to bad debt and the collection agency authorized to place accounts with credit bureaus and/or take legal or judicial action on behalf of Enloe Health as

necessary. At no time will an account be listed with a credit bureau sooner than 180 days from the date of first post discharge billing. Collection agencies will further make reasonable efforts to contact the patient by phone and to notify them 30 days in advance of initiating any ECA's.

REFUND APPROVALS:

- Refund amounts must be approved as follows:
  - Less than $500 PFS Staff
  - $500 to $10,000 PFS Supervisor
  - $10,001 to $35,000 PFS Manager
  - $35,001 to $75,000 PFS Director or Sr. Director of Rev. Cycle Ops. & Tech.
  - Greater than $75,001 Chief Financial Officer

ADMINISTRATIVE ADJUSTMENTS:

- As defined by HCAI (Health Care Access and Information), an administrative adjustment code is used when a decision is made to wave a particular balance for an administrative reason, such as a patient complaint or a settlement offer from an attorney.

- Administrative write-offs related to patient complaints must be approved as follows:

  - Less than $10,000 PFS Supervisor
  - $10,001 to $35,000 PFS Manager
  - $35,001 to $75,000 PFS Director or Sr. Director of Rev. Cycle Ops. & Tech.
  - Greater than $75,001 Chief Financial Officer

- Administrative write-offs related to settlements must be approved as follows:

  - Bad debt patient settlements less than $15,000 — PFS Manager
  - Bad debt settlements greater than $15,000 — PFS Director or Sr. Director of Rev. Cycle Ops. & Tech.
  - Pre-bad debt insurance settlements less than 15 percent — PFS Director or Sr. Director of Rev. Cycle Ops. & Tech.
  - Pre-bad debt insurance settlements greater than 15 percent — CFO

- Administrative write-offs related to bad debt insurance settlements and arbitration settlements must be approved as follows:

  - Less than $75,000 PFS Director or Sr. Director of Rev. Cycle Ops. & Tech.
  - Greater than $75,001 CFO

ADJUSTMENT WRITE-OFF APPROVALS:

- Inpatient and most outpatient reimbursement rates are loaded in the electronic patient

accounting system to calculate expected reimbursement. The contractual adjustment posts at the time the bill drops.

- For those outpatient payers not prorated in the electronic patient accounting system, the contractual on the remittance will be posted at the same time as the payment. Examples of these outpatient payers are, but not limited to, Unlisted Health and Unlisted Worker's Compensation.

- Additional contractual allowances needed to correct complex proration rules, secondary insurance plans, should be submitted through the adjustment workflow in the patient accounting system. The amount must be authorized in accordance with the levels established by this financial policy.

FREE CARE:

- There may be instances when a clinical department, Risk Management, or an administrator requests "free care" or "no charge" for a patient.

- Charges will be posted to the patient account to accurately reflect services rendered.

- The clinical departments, Risk Manager, or appropriate party will contact the PFS Director or Sr. Director of Rev. Cycle Ops. & Tech. to request free care or to waive patient balance.

- The PFS Director or Sr. Director of Rev. Cycle Ops. & Tech., with clinical assistance from the Risk Manager, Case Manager, or Service Recovery Team (SRT), will select one of the following options:

    - Write off all charges to administrative write-off,
    - Bill insurance and write off patient balance to administrative adjustment code,
    - Or bill insurance and patient.

- **Note:** The PFS Director or Sr. Director of Rev. Cycle Ops. & Tech. will escalate the request to the CFO or other administrator if a consensus cannot be reached regarding the appropriate resolution of the request.

BAD DEBT APPROVALS:

- Patient Bad Debt:

    - The collection process and dunning frequency is established in the dictionaries and profile settings within the Patient Accounting System. Statement messages and notifications are designed and intended to comply with all state and federal regulations. For that reason, it is Enloe's policy to allow accounts to automatically transfer to the collection agency without approval.

    - It is the department's standard, however, that:

        - In no instance will adverse credit reporting occur prior to 180 days from the date of first post discharge billing

- All uninsured patients will receive plain summary notice of the hospital's *Community Service and Discount Program,* provided at the time of service, and at least once 30 days prior to initiating any extraordinary collection activities (ECA's).

- Reasonable effort will be made to determine if uninsured patients may be presumptively eligible for Community Service. Such efforts include but are not limited to determining current eligibility with a state or federal program or prior approval under the hospital's *Community Service and Discount Policy.*

- One reasonable attempt to reach patients by phone for all balances over $1,000 will be made.
  - For balances less than $1,000, notice at the time of service and mailed notifications will be considered a reasonable attempt to contact the patient.

- A Final Notice will be mailed on all balances 30 days prior to initiating any extraordinary collection activities (ECA's).

- As it is the patient's responsibility to ensure accurate contact information is on file, in the event of a mail return, one reasonable attempt will be made to contact the patient via phone before referring the account to an outside collection agency for further collection efforts.

- In the situation of minors, absent a court order for financial responsibility of one parent, the presenting parent will be recorded as the responsible parent but one reasonable attempt to contact the other parent prior to initiating any extraordinary collection activities (ECA's) will be made.

- At any time during the 240 days following the first post discharge billing that a patient is presumptively determined to be eligible for Community Service, or requests consideration under the policy, any extraordinary collection activities (ECA's) will be suspended until determination is made and a 30-day notice will be given with any notification of determination to the patient before resuming any extraordinary collection activities (ECA's).

- Once above standards have been met, outside collection agencies are authorized to initiate extraordinary collection activities (ECA's) in compliance with all state and federal regulations. Extraordinary collection activities authorized include but are not limited to reporting of accounts to credit bureaus and legal or judicial processes.

- Insurance Bad Debt:

  - On occasion, it is necessary to assign accounts to a contracted attorney's office for assistance in pursuing an insurance company for payment that cannot be collected by hospital staff. Approval must be documented in account notes as follows:

    - Less than $10,000 PFS Supervisor
    - $10,001 to $35,000 PFS Manager
    - Greater than $35,001 PFS Director or Sr. Director of Rev. Cycle Ops. & Tech.

REFERENCES:

- *Registration of Obstetric Patients*
- *Community Service and Discount Policy*
- *Service Recovery Team Policy*
- *Management of Individuals Presenting for Emergency Care Policy*
- *Forms S8530800 and S8530802*