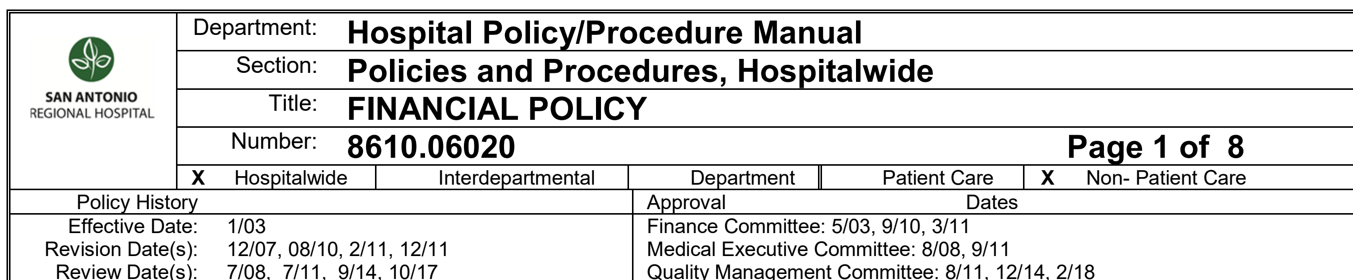

SAN ANTONIO REGIONAL HOSPITAL	Department:	Hospital Policy/Procedure Manual			
	Section:	Policies and Procedures, Hospitalwide			
	Title:	FINANCIAL POLICY			
	Number:	8610.06020		Page 1 of 8	
	X Hospitalwide	Interdepartmental	Department	Patient Care	X Non- Patient Care

Policy History		Approval	Dates
Effective Date:	1/03	Finance Committee: 5/03, 9/10, 3/11	
Revision Date(s):	12/07, 08/10, 2/11, 12/11	Medical Executive Committee: 8/08, 9/11	
Review Date(s):	7/08, 7/11, 9/14, 10/17	Quality Management Committee: 8/11, 12/14, 2/18	

PURPOSE:

To ensure that patients are aware of their obligation to pay for health care services, and to provide payment alternatives which will facilitate such payment; thus reducing the average collection period of accounts receivables, enhancing cash flow, reducing bad debts, and better enabling San Antonio Regional Hospital (SARH) to meet operating and capital expenditure requirements necessary for the provision of medical services within the community. To ensure Hospital complies with all state and federal regulations relative to the Fair Pricing Policies and Debt Collection (Health and Safety Code, Article 3, beginning with Section 127400) and the Patient Protection and Affordable Care Act (PPACA).

POLICY:

I. It shall be the policy of SARH to administer a financial policy that will contribute to the goal of maintaining a full service health care facility. This will be facilitated through patient communication and the timely collection of its accounts receivable, ensuring that those who can pay, do so. Those who are unable to pay for their hospital care may be offered assistance to determine their eligibility for other financial assistance or charity care programs including, but not limited to, external programs (e.g., Medi-Cal, Healthy Families, CCS, County MIA, etc.) and internal programs (e.g., Discount Care Policy, Charity Care, Long Term payment arrangements, etc.). Hospital will provide Medi-Cal/Healthy Families applications to the patient upon identification that the patient may be eligible for assistance from these programs or upon request from the patient.

II. SARH will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

PROCEDURE:

I. All accounts are due and payable at the time of discharge/service. This requirement may be waived if the patient has insurance or other third party coverage, or has made acceptable financial arrangements. It is the patient's and/or guarantor's responsibility to pay for services rendered by the hospital, unless specifically excluded from doing so in a contract between SARH and a third party payor (e.g., HMO, PPO, POS, etc.) As a courtesy, SARH will bill the insurance carrier when benefits have been assigned to the hospital. The hospital will allow 60 days from the date of billing for payment to be made by the insurance carrier. During this 60-day period, the hospital will perform follow-up activities to ensure the claim was received and to provide any additional information that may be necessary to process payment. After 60 days, the hospital will look to the patient/guarantor for resolution of the outstanding balance. The hospital will continue to make reasonable efforts to work with the patient to obtain payment from the insurance carrier. Should the insurance

carrier delay, deny, or disallow any portion of the services, the hospital will seek payment from the patient. (Exception to these procedures will be made for patients enrolled in a federally qualified HMO, or in accordance with a managed care agreement between the hospital and the patient's insurance carrier. Follow-up on these accounts will be in accordance with state/federal regulations and the managed care contract.)

II. All patients shall be billed, in a timely manner, at the hospital's usual and customary rates in effect at the time of service. Patients will not be responsible for amounts discounted as the result of contractual agreements with third parties.

III. SARH will post notices regarding the availability of charity, discount, and financial plans available to our patient. Such notices will be placed in various locations including the emergency department, billing office, admission office, and other outpatient settings. Notice may also be placed in other sources such as sach.org and hospital-generated publications.

IV. **Admissions**:

A. The admitting/ordering physician and patient are encouraged to provide the hospital with advance notice of all admissions. When possible, Admitting staff will pre-admit all patients. Pre-Admission shall include verification of insurance eligibility, benefits, and notice to appropriate utilization review agencies.

B. Scheduled Admissions – No patient will be refused admission to the hospital due to inability to pay for service, if an immediate (i.e. emergent/urgent) need for hospitalization exists. If immediate hospitalization is not necessary and the patient/guarantor is unable to pay or to make acceptable payment arrangements, the patient's physician may be contacted to consider other treatment alternatives (e.g., same day surgery, observation, outpatient diagnostic testing, or use of other medically-appropriate facility). Postponement of admission, only with the approval of the physician, shall be considered.

C. Elective Admissions – In the case of elective admissions, patients may be notified by telephone of verified insurance benefits. Based upon verified benefits and estimated total charges, the patient will be asked for deductibles, co-insurance, and other non-covered amounts at admission or prior to discharge. If the patient has any other outstanding debt to the hospital, the balances will be collected, or a payment arrangement agreed upon, prior to admission.

D. Urgent/Emergent Admissions – In the case of an urgent or emergent admission, the same process of verification of insurance benefits and notification to review agencies shall occur. The patient shall be notified of benefits and any deductibles or co-insurance amounts due once their condition has stabilized. This notification may take the form of a personal contact by the Financial Counseling staff, provided the patient's medical condition permits and clearance has been provided by nursing staff and/or the patient's attending physician. Under no circumstances will the health of the patient be jeopardized.

E. San Antonio Regional Hospital does not have differing standards of obstetrical care based upon a patient's source of payment or ability to pay for medical services (Health & Safety Code 1256.2).

V. **Discharge**:

A. At the time of discharge, all patients/guarantors will be requested to pay the difference between estimated insurance benefits and total charges, or applicable deductibles or co-insurance. All uninsured patients will be requested to pay 55% of total charges. In the event payment at time of service is not possible, a Financial Counselor/Advocate will review payment alternatives and the guarantor (see Payment/Collection procedure) will select an option.

B. Payment is due at the time of discharge unless other financial arrangements have been made.

VI. **Transfer:**

A. No patient will be refused emergency treatment/admission due to inability to pay. Without regard to finances, patients presenting to the Emergency Department will receive a medical screening examination to determine the need and method of medically necessary treatment. Patients requiring admission, but who do not have verifiable insurance and/or the financial means to pay for services rendered by SARH, will be evaluated for transfer to the appropriate county facility or another contracting facility only upon approval of the patient, the attending physician, and in accordance with all state, county, and/or federal regulations. A patient whose medical condition has been determined to be medically unstable will not be denied admission unless SARH is unable to provide the medical services or the medically necessary level of care.

VII. **Outpatient Services**:

A. Outpatient/Emergency Department – No patient will be refused treatment due to their inability to pay if there is an urgent/emergent need for treatment. However, all outpatient and emergency department services are to be paid for in full at the time of service, unless the hospital is contractually precluded from collecting such amounts, or it can be demonstrated that full insurance coverage exists. Emergency Room patients will not be asked for payment until after the completion of the medical screening examination and the physician's confirmation that the patient's medical condition is stable. If an outpatient is unable to pay and acceptable financial arrangements have not been made, postponement of the test(s) may be considered with the approval of the physician.

B. Same Day Surgery – All elective same day surgery admissions will be pre-admitted. Verification of insurance eligibility, benefits, and notice to appropriate utilization review agencies shall be made prior to the patient's admission. Patients will be notified of verified benefits prior to admission. Patients will be asked to pay the difference between verified insurance benefits and contractually allowed amounts including any deductibles and

co-insurance. If the patient is unable to pay and acceptable financial arrangements have not been made, postponement of the procedure may be considered only with the approval of the physician.

C. Recurring outpatients registered in on-going treatment programs (e.g., physical and radiation therapy, respiratory care) will be billed monthly. Patients with accounts in excess of 60 days past due will be responsible for any outstanding balance. Exceptions include balances pending payment from HMOs, Medicare, and/or Medi-Cal.

VIII. **Insurance and Self-Pay Billing/Follow-Up:**

A. SARH will follow the guidelines detailed below in the billing and follow-up of outstanding patient accounts

B. All insurance information will be requested from the patient. The patient/insured must assign insurance benefits directly to SARH, or the patient will be financially responsible for 100% of the hospital's billed charges. SARH will bill insurance as a courtesy to the patient; however, the patient is responsible for full payment of billed charges (or the contractually allowed amount, if so stipulated in the health plan agreement) if the insurance fails to pay within 60 days from the date of billing (unless precluded under state/federal regulations). SARH will attempt to collect patient-due balances concurrently with collection of insurance balances. Contact will also be initiated with the third party payors in order to expedite payment. Patients who do not have 100% insurance coverage will be asked for a deposit (i.e., deductible and/or co-insurance amounts) prior to admission. Any outstanding balances due will be requested at the time of discharge.

C. Medicare – SARH will bill Medicare on behalf of Medicare beneficiaries. In-Patient deductible and co-insurance amounts will be requested at the time of admission or discharge. Medicare beneficiaries will be billed, following Medicare's payment, for applicable deductible and/or co-insurance on outpatient/emergency room services. Supplemental insurance plans will be billed following payment from Medicare.

D. HMO/PPO – SARH will bill all contracted managed care plans (e.g., HMO, PPO, POS, etc.) when valid insurance information is provided to the hospital. Co-payments, deductibles, and co-insurance will be requested at the time of admission/registration or prior to discharge. SARH will initiate consistent on-going efforts to ensure payment for services rendered in accordance with applicable HMO/PPO contractual agreements. Accounts may be assigned to an outside agency for collection if the insurance carrier fails to pay and the hospital is legally precluded from billing the patient; or, the hospital determines the plan is engaging in unfair practices that result in the consistent underpayment (or non-payment) of claims. SARH may file a formal complaint with the Department of Insurance or Department of Managed Health Care. SARH will assist the patient in filing any necessary appeals.

E. Self-Pay – Patients with no insurance coverage receive an automatic 45% discount from billed charges. Patients will be asked for a deposit of the estimated total charges (less 45%), at the time of admission/service. Patients unable to meet the foregoing requirement may be considered for other financial assistance, including: extended payment arrangements (not to exceed six (6) months), longer term payment arrangements with a third party financial institution, federal/state/local programs, and/or charity care (see Payment/Collection procedure). In the event that financial arrangements cannot be concluded prior to the proposed admission date and the admission or service is of an elective nature, the physician may be contacted to postpone the admission until such time as acceptable financial arrangements can be completed. Any late charges will be payable within 30 days of receipt of the initial billing.

F. Workers' Compensation – SARH will accept and bill all verified workers' compensation cases until payment in full is received. Outside third party reductions in charges for services rendered will not be accepted, other than in accordance with contracting insurance plans.

G. Medi-Cal – SARH is not a contracted Medi-Cal provider. Applicable verification of benefits and authorization (e.g., Treatment Authorization Request) is required for all inpatient services. Services rendered in the Emergency Department do not require prior authorization. Outpatient Ancillary services *may or may no*t require prior authorization. If prior authorization is required, authorization will be obtained prior to rendering the service. Patients who are unable to demonstrate proof of eligibility at the time of service will be considered self-pay. The Hospital must have the patient's BIC number showing an effective Issue Date in order to bill Medi-Cal. A deposit will be requested for all non-emergent/urgent outpatient services. The deposit will be refunded when proof of eligibility is provided. SARH will provide inpatients with assistance in applying for Medi-Cal.

SARH will maintain a supply of Medi-Cal and Healthy Families applications in Admitting, Outpatient, the Emergency Department, and Patient Accounts. Patients may also contact the Healthy Families/Medi-Cal Information Line at 1-800-880-5305. Applications may be downloaded at: http://www.healthyfamilies.ca.gov/Downloads/Applications.aspx

H. Medicare Part B Only – As SARH is precluded from billing inpatient services for Medicare beneficiaries with Part B only benefits, and as most Part B only beneficiaries are also covered by Medi-Cal, Admitting will contact the admitting physician and ask that the patient be redirected to a Medi-Cal contracting facility if the physician is ordering (non-emergent) inpatient or same day surgery services.

I. Liability Cases – SARH does not accept third party liability insurance for auto accidents and disputed workers' compensation cases. Insurance companies will be asked to provide a letter guaranteeing payment, for services rendered, directly to the hospital. If the insurance company does

not provide a letter guaranteeing payment, the services will be considered self-procured and payable by the patient/guarantor.

IX. **Payment/Collection Procedure:**

A. Every effort will be made to collect a deposit, deductibles, and/or co-insurance at the time of admission/service. The Director of Business Services or his/her designee shall have sole authority for making exceptions to the deposit requirement.

B. Upon verification of insurance coverage and benefits, and prior to discharge, a Financial Counselor will make every effort to review the anticipated patient balance due with the patient/guarantor.

C. The Financial Counselor will talk with the patient/guarantor and discuss alternatives that may be available based on the patient/guarantor's financial situation. The patient/guarantor will be asked to select and agree to an available option.

1. Payment in full of the estimated patient balance will be requested at the time of discharge. Payment may be made by cash, check, or credit card. Patients unable to meet this requirement may be considered for other financial assistance (see Section B-E below). Additional charges not available upon discharge or service shall be paid upon receipt of the first billing.

2. Patients/guarantors unable to pay under the foregoing option may be referred to an outside financial institution (i.e., Bank of Nevada) that has agreed to extend longer-term financing of accounts on balances that will require more than 90 - 180 days to pay in full. Bank of Nevada will initiate contact with the patient by the forwarding of a balance due statement and a request for payment. Such communication will include the option to pay a reduced rate (4% of the balance or $25 whichever is less) or payment in full. If the patient defaults on their payment to Bank of Nevada for more than two months, Bank of Nevada will notify the hospital and the account will be write-off as a bad debt and assigned to an outside collection agency. Assuming that payments are made in a timely manner and in accordance with the terms of the Bank of Nevada contract, the patient/guarantor will have the option of adding future balances to the outstanding debt.

   The hospital will receive a direct deposit of funds each month from Bank of Nevada. The accounts will remain on the active Accounts Receivable and only be reduced by each month's payments. Accounts will be identified through the assignment of a unique financial class.

3. Every effort will be made to collect estimated amounts due at admission, time of service, or prior to discharge. Accounts paid within 90 - 180 days of discharge/service will have the late payment fee waived. Accounts outstanding beyond 90 days, for which no

formal payment arrangement has been established, will be assessed a late payment fee from the date of discharge/service at the rate of 1.5% per month (annual percentage rate is 18%) of the adjusted balance. If a patient is eligible under the Discount Care Policy, payments will be interest free. No account (excluding those accounts designated in the Bank of Nevada financial class) shall be maintained on the hospital's active accounts receivable in excess of six months without the approval of the Director of Business Services or his/her designee.

4. A patient/guarantor that cannot pay their account in full within 90 - 180 days and who does not qualify for outside financing will be offered the opportunity to establish a payment program with an outside collection agency. The account(s) shall be removed from the hospital's accounts receivable file. Such payment programs shall not be reported to any credit reporting agency unless the debtor defaults on payments to the agency.

5. In the event a patient/guarantor can substantiate an inability to pay due to their uninsured status or high medical costs (as provided in AB 774 and/or SB 350), and no other payment source can be established, the Charity Care (8610.03040) and Discount Care (8610.04010) policies shall be followed. This requirement remains in effect even if the account has been assigned to an outside collection agency.

X. **Collection Activities**

A. SARH will attempt to collect all outstanding balances consistent with the terms and guidelines noted above. Accounts for services rendered to patients that do not conform to the terms of their financial arrangements will be deemed uncollectible and removed from the active accounts receivable file. Any account meeting the above criteria shall be referred to an outside collection agency for further collection effort. Assignment to a collection agency may result in notice to credit-reporting agencies and legal action against the patient, guarantor, and/or insurance carrier.

B. At no time will hospital, its assignee, or any collection agency report adverse information to a consumer credit reporting agency or commence civil action against the patient for non-payment at any time prior to 150 days after initial billing.

C. When a patient is attempting to qualify under the Hospital's Charity Care or Discount Care Policies and is attempting, in good faith, to settle an outstanding bill by negotiating a reasonable payment plan, then the hospital shall not send the outstanding bill to a collection agency or other assignee unless that entity agrees to comply with AB 774 and SB 350

D. When dealing with a patient under the Charity Care or Discount Care Policies, the hospital, or other assignee that is affiliated with the Hospital, may not use wage garnishments or liens on primary residences as a

means of collecting unpaid hospital bills. (Health & Safety Code § 127425(f)(1).

E. Collection Agency(ies) Agency(ies) may not use wage garnishments as a means of collection unpaid hospital bills except by order of the court (Health & Safety § 127425(f)(2)(A)), or sale of the patient's primary residence (Health & Safety Code §127425(f)(2)(B)).

F. The collection agency may not begin collection activities against a patient without first providing the patient with a statement of the availability of credit counseling services and a short written description of the patient's rights under state and federal fair debt collection laws. Such notice shall also include a document indicating that collection activities may occur.

G. Collection Agency(ies) will provide Hospital with a written agreement that specifies that such agency(ies) will adhere to the hospital's process and procedures regarding the collection of patient debt.

XI. Exceptions to the Financial Policy may be made only as herein referenced or by the Senior Vice President of Finance or President/CEO.

REFERENCES:

(Previously Business Service Policy/Procedure #8531.10002 *Financial Policy*)

AB774

SB350

California Health & Safety Code §127400 – 127446

Patient Protection and Affordable Care Act

RELATED POLICIES/ATTACHMENTS/FORMS:

Hospital Policy/Procedure #8610.03040 *Charity Care*

Hospital Policy/Procedure #8610.04010 *Discount Care*