

Touchette Regional Hospital	Department: Business Office	Policy #: BO.1016
	Author: Revenue Cycle Director	Original Effective Date: 04/09
	Title/Subject: Billing and Collection Policy	Reviewed:
		Revised: 12/15, 01/18

Policy Statement:

The Business Office is committed to applying fair and consistent procedures for collecting payments for balances that remain after all discounts, financial assistance, and payments have been applied. Touchette bills and collects in accordance with current Federal, State of Illinois Health, and Financial Services laws and regulations guided by Illinois Hospital Association recommendations and best practices. Touchette Regional Hospital does not base a patient’s ability to pay on the quality of the services that a patient receives. We do not discriminate based on race, age, gender, handicap, or sexual orientation.

Scope:

Business Office

Definitions:

Amount Generally Billed (AGB) – Taken from the hospital’s Provider Statistical and Reimbursement System (PSR) Report using fiscal year 2017 data, this amount is the sum of gross Inpatient Part A and Outpatient PPS covered charges divided into the sum of net reimbursement (amounts allowed). The AGB is calculated annually based on the prior full year’s PSR Report. For 2018, this is based on 2017 data.

Charity –A patient who has been screened for Financial Assistance and, based on financial information provided for the household has been approved for a discount or full adjustment of hospital-billed charges.

Charity Pending – A patient who has applied for charity but the screening process could not be completed because of missing information or documentation (such as proof of income), or where additional questions need to be answered in order to complete the application.

Charity Presumptive – a patient who does not have Medicaid, but who is receiving one of the benefits or qualifies for one of the following programs:

Illinois Free Lunch & Breakfast Program
Women, Infants and Children Program (WIC)
Supplemental Nutrition Assistance Program (SNAP)/food stamps/ LINK
Enrolled in Temporary Assistance for Needy Families (TANF)
Enrolled in Illinois Housing Dev Authority Rental Housing Support
Low Income Home Energy Program (LIHEAP)
Has file bankruptcy within the past 6 months
Is homeless

Emergent Care – Care obtained through the Emergency Department or as determined based on a physician’s examination and deemed required procedure for patient’s immediate health need.

Extraordinary Collection Actions (ECAs) – Additional efforts to collect a debt that has gone beyond 120 days of billing with no payment or payment agreement. Efforts may include but are not limited to reporting adverse information about the account to a consumer credit reporting agency, placing a lien on patient assets, or garnishing individual wages.

Self Pay- A patient who has no health insurance and/or who does not qualify for Financial Assistance based on our hospital policy. An account is also considered Self Pay if there is a balance after all payments, discounts, and financial assistance has been applied.

Uninsured – A patient who has no health insurance coverage at all and who also does not have a pending liability case pending on the services that will be rendered.

Underinsured – A patient who has health insurance coverage which leaves the patient with a balance or insurance that doesn’t cover certain procedures.

Procedure:

After all expected payments have been received from third party payors (Medicare, Medicaid, Commercial, Worker’s Compensation, and Other, adjustments are made per contracts with the hospitals. If the patient was qualified for financial assistance, an adjustment will be made to the patient’s account. If the patient did not qualify for financial assistance and did not have insurance at the time, the patient will be billed at Amounts Generally Billed (ABD) which, for 2018, is after a discount of 38% of total charges. Any remaining balance becomes Self Pay and is the responsibility of the patient.

The Business Office sends all accounts to an outsourced Early (Pre-Collect) agency after the bill becomes a self-pay balance. This agency, working as an extension of our Business Office, will attempt to collect the payment or make an agreement with the patient to accept payments on the balance. Telephone contact with the patients will begin no earlier than 14 days after receiving the account from the hospital, allowing the patient to respond to the initial hospital letter. For balances under \$20, the agency will send a statement only upon request. Additional mail may be sent throughout the period the agency is holding and working the account.

Medicare

Medicare (for age 65+ and/or with a qualifying disability) patients may be asked for a deposit and/or co-pay in accordance with the Hospital Payment Policy and the service being provided by Touchette Regional Hospital.

After a minimum of 120 days of unsuccessful collections and/or correspondence from the patient, the agency will return the account to the Business Office. Working in accordance with the Medicare regulations, a bill that remains unpaid more than 120 days from the date the first letter was mailed to the beneficiary may be deemed bad debt.

Medicare bad debt must meet the following criteria to be allowable:

- The debt must be related to covered services and derived from deductible and coinsurance amounts;
- The provider must be able to establish that reasonable collection efforts were made;
- The debt was actually uncollectible when claimed as worthless; and
- Sound business judgment established that there was no likelihood of recovery at any time in the future

If the account meets these criteria, the account will be sent to a contracted collection agency and defined as “Bad Debt.” The agency will continue to make reasonable efforts to contact the patient and collect the balance.

Self Pay Balances (Non-Medicare)

Once an account has a balance that has been determined to be “Self Pay,” the account will be forwarded for a minimum of 120 days to an outsourced pre-collect agency working as an extension of the Business Office. The agency will make reasonable efforts on our behalf to collect the balance from the patient and is able to set up payment schedules that extend beyond 30 days to work with the patients. Once an account is at least 120 days old and has not had success in collecting from the patient, the account will be returned to the Business Office.

The Business Office will change the status of the account to “Bad Debt” then will forward it to a contracted collection agency that will continue to make reasonable efforts to contact the patient and collect the balance using Collection Actions including reporting to credit bureaus.

In compliance with federal Section 501(r), applications will be accepted and considered at least 240 days after the first invoice. Should an application be submitted before the 240 days but after the account has been sent to collections, the agency will return the account to Touchette Regional Hospital who will review the application and determine financial assistance eligibility.

Related Documents: BO1006 Financial Assistance Policy, BO1017 Medicare Bad Debt

Signatures:

Approved: _____ Date _____
Director of Revenue Cycle

Approved: _____ Date _____
Chief Financial Officer