BLUEFIELD REGIONAL MEDICAL CENTER

POLICY NAME: Billing & Collection Procedures for Self Pay Balances	POLICY # 401
DEPARTMENT: Patient Access	PAGE 1 of 4 EFFECTIVE: 10/17/19
REVIEW DATE: 3/4/2020	REVISED: 3/4/2020

STATEMENT OF PURPOSE: The purpose of the policy is to set forth the guidelines for collection of Self-pay balances due to meet the requirements related to collection action for non-profit facilities as defined by the Affordable Care Act.

RATIONALE: To provide procedures for working Self-pay balance accounts.

SCOPE: Patients are sent statements and accounts are called on as appropriate prior to placement with external vendors. External Vendors are required to provide appropriate notification to patients and follow Bluefield Regional Medical Center's ("Hospital") policy on the same.

Responsible Party:

Patient Access Staff:

PROCEDURE:

- Publicize Hospital's Financial Assistance Policy ("FAP") by offering a paper copy of the summary of the FAP to patients who present to Patient Access Financial Counseling.
  a. Patient presenting to Patient Access Financial Counseling are asked to pay. If the patient states that he or she is unable to make payment – staff advises of Financial Assistance program, refers to Medicaid Eligibility vendor as appropriate for Medicaid application and inquires as to whether the patient would like a copy of the FAP.
  b. When Financial Assistance application is taken and decision of approval/denial is made in writing the application is scanned for record detention.
  c. FAP can be accessed on website – https://bluefieldregional.com
- The billing statements include a notice on availability of financial assistance, phone number at the Hospital to contact for more information & direct website address where copies of the FAP application form and summary may be obtained. Verbiage: "To inquire about FINANCIAL ASSISTANCE or to establish a payment plan, call (304) 327-1632 or (304) 325-1912 or visit our website at https://bluefieldregional.com."

- Patients are sent a total of three statements and a phone call is attempted after the third statement and before the account is turned over to an outside Vendor/Agency.
- Report is run weekly and all accounts are called on for payment arrangements and to determine if eligible for Financial Assistance.
- At the time of phone call to the patient, the clerk is to verify if the patient has been previously advised by Patient Access staff and given a copy of the summary of the FAP and-or would require another copy of the FAP and if wanted to apply for Financial Assistance.
- If patient is unable to pay in full, and subject to legal limitations, then monthly payments are set up in accordance with the tiered schedule listed below for patients who do not apply or qualify for the Financial Assistance program.
- If a patient is unable to set up payments under the tier schedule below, financial information is requested and reviewed with the Patient Support/Credit/Collection Manager for approval.

Monthly payments under the plan B regular tier option.

Amount Due	Minimum Payment	Maximum Months
$ 10.00 to $ 250.00	$ 25.00	6 months
$ 251.00 to $ 500.00	$ 50.00	7 months
$ 501.00 to $1,000.00	$ 75.00	12 months
$1,001.00 to $5,000.00	$100.00	24 months
$5,001.00 to Unlimited	$200.00	24 months

- The uninsured report is worked monthly and if no response is received from the patient or contact from the Medicaid Eligibility Vendor or Department of Health & Human Resources (DHHR) is noted, a phone call is made for payment arrangements/financial assistance referral. Reference to Policy Bolder/DHHR referrals – PCH.PTAC.029.

- Before accounts are placed with the Early Out vendor verify the following:
  Patients have been advised of the facility Financial Assistance policies.
  Confirm all three statements have been sent, attempts to contact by phone have been made and documented. The Early Out vendor and the Hospital will not pursue any extraordinary collection actions for at least 120 days from the date the Hospital provides the first post discharge billing statement to the patient.

Early out Vendor Process:

1. Accounts are placed with Cash Flow Management (CFM), an early out Vendor to collect. Vendor retains the account for 120 days and if unable to collect the account, it is returned to the Hospital.
   - CFM statements and letters contain appropriate verbiage in compliance with the Affordable Care Act – this is confirmed annually.
   - CFM does not report to a credit bureau.

2. Upon receipt of the file, the account is downloaded to system and a letter with a return envelope is mailed to the patient asking for payment in full. Included in the letter, "If you believe you may qualify for our financial assistance program, please contact the hospital at 304-327-1632 or 304-325-1912; our policies can be accessed by phone and also on the website at http://bluefieldregional.com."
    - All accounts are loaded into the collector's chain within 24 hours thereafter and calls begin Monday through Saturday 8 am – 8 pm in an attempt to contact the patient for payment in full or to schedule a payment plan.
    - Patients who set up a payment plan (where consistent with legal limitations) receive a notice with a return envelope 10 days prior to the due date of each payment deadline until the account is paid in full.
    - Patient who miss a payment or do not respond to calls and letters continue to be contacted; at minimum, once each week until the account is returned at 120 days for placement with the primary agency/attorney.
3. Bluefield Regional Medical Center utilizes a predictive model prior to placement of accounts for Collection with the Primary Bad Debt Collection Agency to score individual ability to pay, based on defined criteria. Patients may be eligible for a Financial Assistance application discount as defined by the Financial Assistance Policy (Policy #405).

Primary Vendor Policy:

1. If ineligible for assistance and the patient's balance remains unpaid, the account is placed with the primary vendor Feuchtenberger and Barringer Legal Corporation (FBLC). FBLC retains the account for 180 days and if no response is received from the patient, the account is returned to the hospital.
    - FBLC statements and letters contain appropriate verbiage as defined in compliance with the Affordable Care Act. This is reviewed annually.
    - FBLC does not report to credit bureau in compliance with the Affordable Care Act. This is confirmed annually.
    - FBLC checklist contains requirements to be met (checklist attached).
2. FBLC Process:
    - Send #1 Notice and skip trace if needed. First notice by law gives 30 days to dispute.
        a. The first notice sent includes the following: "This account is ready for legal action, if you feel you are eligible for the Financial Assistance program please contact the Hospital at 304-327-1632 or 304-325-1912." FBLC first notice gives 30 days to dispute the validity of all or any part of the debt.
    - Send #2 Notice and/or Proof of Claim, telephone contact.
    - Send #3 Notice and request D-50.
    - After 180 days , if any unpaid balances remain and there are no payment arrangements established, the account will be closed.

Extraordinary Collection Action:

- Following documented reasonable efforts (including an oral communication to notify the patient about the Hospital's Financial Assistance Policy at least 30 days before initiating an extraordinary collection action) to notify the patient about the Financial Assistance Program and how to get application assistance, patient provided with a manager approved communication that informs the patient that financial assistance is available for eligible individuals, provides a copy of the plain-language summary of the Financial Assistance Policy, and gives the patient at least 30 days prior written notice that the Hospital intends to initiate legal action or pursue any other extraordinary collection action.
- Extraordinary collection procedures are periodically reviewed by legal counsel.
- Accounts recommended for legal action are received by the Patient Support Service Manager from the Primary Vendor/Agency.
- Letter is sent following appropriate review/approvals by Patient Support Service Manager. (Attached)
- BRMC letter provides 30 days for response and holds any action an additional 15 days before proceeding. (Attached)
- Check off list is completed confirming all requirements have been met including time lines and reviewed by Patient Support Service Manager to confirm prior to authorizing Agency to proceed.

Reviewed by: BK

Title: VP OF FINANCE

Date: 03/05/2020