

 <b>Sheppard Pratt</b> HEALTH SYSTEM		Policy Number: HS-130.12
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Manual: Sheppard and Enoch Pratt Hospital Administrative Manual		Effective: 10/9/2018
Section: 100 - Health System	Sub-section: 130 - Finance	Prepared by: Ray Dzieszinski
Title: Billing and Collections Policy		

## POLICY

Sheppard Pratt Health System ("Health System") is dedicated to providing patients with the highest quality of care and services. In support of this goal, the Health System is committed to billing patients and applicable payers accurately and in a timely manner pursuant to this Billing and Collections Policy ("Policy"). All outstanding accounts will be handled fairly and in accordance with the requirements of Code Section 501(r) and regardless of race, color, creed, religion, gender, national origin, age, marital status, family status, handicap or other discriminatory factors.

## PURPOSE

To institute a comprehensive revenue cycle approach using accepted collection practices while giving proper attention to the rights and the dignity of the patient, guarantors and other responsible parties.

## PROCEDURE

1. Definitions. The following terms are meant to be interpreted as follows within this Policy:
  - a. Code Section 501(r): Section 501(r) of the Internal Revenue Code of 1986 and the regulations promulgated thereunder, as amended from time to time.
  - b. Extraordinary Collection Actions (ECAs): Collection activities, as defined in Code Section 501(r) that healthcare organizations may only take against an individual to obtain payment for care after reasonable efforts have been made to determine whether the individual is eligible for financial assistance. ECAs are those activities identified under Code Section 501(r), which may include:
    - i. Selling an individual's debt to another party, unless the purchaser is subjected to certain restrictions as provided in Code Section 501(r).
    - ii. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.
    - iii. Actions that require legal or judicial process, except for claims filed in a bankruptcy or personal injury proceeding.
  - c. Financial Assistance Policy (FAP): A separate policy that describes Health System's financial assistance program for medical services. This policy includes the criteria patients must meet in order to be eligible for financial assistance as well as the process by which individuals may apply for financial assistance.
  - d. Responsible Party: With respect to services provided by the Health System, the patient, account guarantor, or other person responsible for paying for such services.
  
2. Payment Policy/Past Due Accounts.

- a. For services covered by insurance, an attempt should be made to collect all co-pays and deductibles at the time of service. If the patient is unable to pay at the time of service, arrangements should be made for payment of any self-pay amounts due at the time of the visit.
- b. All self-pay amounts due will be billed to the responsible party via a monthly statement. These amounts include unpaid co-pays and/or deductibles, co-insurance and other amounts due after insurance. The monthly statement clearly indicates that the charges are for hospital services only and that charges for physicians' services are not included. A contact telephone number is listed on the statement for the responsible party's convenience.
- c. All self-pay amounts due are expected to be paid in full by the responsible party upon receipt of the monthly statement. If the responsible party is unable to pay the full amount due, they are expected to contact the Finance Office to make suitable arrangements for payment. If the responsible party indicates a financial hardship, the Health System's FAP, FAP application form, and plain language summary are forwarded for completion by all responsible parties on the account. To accommodate payment requests, financial information may be requested and, pending a review of financial circumstances by a Patient Fiscal Services Manager, a payment plan may be offered.
- d. If pre-collection efforts are successful but the account is not paid-off, acceptable payment arrangements will be made with the Patient Fiscal Services Manager and the account will be removed from the collection process. Those accounts which have neither responded to pre-collection efforts nor made satisfactory payment arrangements may be subject to further action pursuant to Section 3 and the timeframes provided therein. At this point, the account will be written-off to bad debt from the active A/R.
- e. At the direction of the Collection Supervisor, the Director of Patient Accounting or other upper management, a delinquent account may bypass both the pre-collection and collection process and be forwarded/referred directly to the attorney for collection. An account may also be removed from either the pre-collection or collection process at any time upon the direction of the aforementioned personnel and be sent to the attorney for collection. All accounts forwarded directly to the attorney for collection are written-off to bad debt. Furthermore, as part of this process, the attorney is contractually obligated to ensure that no ECAs are taken to obtain payment for the care until reasonable efforts have been made to determine whether the individual is FAP-eligible for the care.
- f. On those accounts referred to an attorney for collection, the attorney will make reasonable efforts, consistent with Section 3, to resolve the account before seeking judgment. If the attorney is unable to negotiate an acceptable resolution, judgment will be pursued. After securing judgment, the attorney may issue wage and/or bank account attachments or other legal actions to enforce the judgment. If it is determined by the attorney that there are assets available to satisfy all or part of the debt no action of any kind may be initiated without specific authorization from the Vice President of Finance.
- g. These collection policies apply to all responsible parties regardless of previous collection or payment history with the exception of those responsible parties with open accounts currently at the collection agency or with the attorney. In those circumstances, accounts may bypass the pre-collection process if the requirements of Section 3 are met.
- h. The Health System does not charge any interest, late fees or penalties on any accounts.
- i. The Health System does not permit any of its collection agencies to report accounts to any credit reporting agency or to pursue legal action on any of its accounts.

### 3. Reasonable Efforts and Extraordinary Collection Actions (ECAs).

- a. Before engaging in ECAs to obtain payment for care, Health System must make certain reasonable efforts to determine whether an individual is eligible for financial assistance under the FAP. The Patient Financial Services Department is responsible for ensuring that Health System undertakes reasonable efforts to determine eligibility for financial assistance pursuant to the FAP and this Policy.
- b. Complete FAP Applications. In the case of a patient who submits a complete financial assistance application form, Health System shall, in a timely manner, suspend any ECAs to obtain payment for the care, make an eligibility determination, and provide written notification, as provided in this Policy.
- c. Presumptive Eligibility Determinations. If a patient is presumptively determined to be eligible for less than the most generous assistance available under the FAP (for example, the determination of eligibility is based on an application form submitted with respect to prior care), Health System will notify the patient of the basis for the determination and give the patient a reasonable period of time to apply for more generous assistance before initiating an ECA.
- d. Notice and Process Where No Application Submitted. Unless a complete application form is submitted or eligibility is determined under the presumptive eligibility criteria of the FAP, Health System will refrain from initiating ECAs for at least 120 days from the date the first post-discharge billing statement for the care is sent to the patient. In the case of multiple episodes of care, these notification provisions may be aggregated, in which case the timeframes would be based on the most recent episode of care included in the aggregation. Before initiating one (1) or more ECA(s) to obtain payment for care from a patient who has not submitted an application form, Health System shall take reasonable actions to inform the patient of the availability of financial assistance for eligible patients, including the provision of written notice thirty (30) days in advance of initiating one or more ECAs.
- e. Notification of Approval or Denial for Assistance. As provided in the FAP, The Patient Financial Services Department will notify the patient in writing within a reasonable period of time of the receipt of the application form as to whether the application was approved or denied. If the application was approved, the letter will include the amount of assistance approved. If the application was denied, the denial reason will be provided in this letter.
- f. Incomplete FAP Applications. For incomplete applications, patients will be provided with a list in writing of the information and/or documentation still needed to complete the application form and where to submit the missing information. Patients shall have at least thirty (30) calendar days to submit additional information. Any pending ECAs shall be suspended during this time.
- g. ECAs. After making reasonable efforts to determine financial assistance eligibility as outlined above, Health System may take one or more ECAs to obtain payment for care.
- h. Reversal of ECA(s). To the extent a patient is determined to be eligible for financial assistance under the FAP, Health System will take all reasonably available measures to reverse any ECA taken against the patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the patient, lift any levy or lien on the patient's property, and

remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

- i. Refunds. As provided in the FAP, a patient can apply for financial assistance at any point in the collection cycle. However, a refund will only be allowed during the "application period." The application period begins on the date care is provided and ends on the later of the 240th day after the date the first post-discharge statement for the care is provided or either: (i) the date specified in a written notice from Health System regarding its intention to initiate ECAs; or (ii) in the case of a patient who has been deemed presumptively eligible for financial assistance less than 100%, the end of the reasonable time to apply for financial assistance. Health System will provide a refund for the amount a patient has paid for care that exceeds the amount the patient is determined to be personally responsible for paying under the FAP, unless such excess amount is less than \$5.00. Furthermore, this refund provision shall not apply to payment(s) made by a patient that pre-date a patient's change in circumstances that causes a patient to become eligible for assistance under the FAP, as determined at the sole discretion of the Health System.
  - j. Restrictions on Deferring or Denying Care. If the Health System intends to defer or deny, or require a payment before providing, medically necessary care, as defined in the FAP, because of a patient's nonpayment of one or more bills for previously provided care covered under the FAP, then the patient will be provided an application form and a written notice indicating that financial assistance is available for eligible patients and stating the deadline, if any, after which Health System will no longer accept and process an application submitted (or, if applicable, completed) by the patient for the previously-provided care at issue. This deadline shall be no earlier than the later of thirty (30) days after the date that the written notice is provided or 240 days after the date that the first post-discharge billing statement was provided for the previously provided care.
4. Additional Pre-Billing and Pre-Collection Financial Assistance Review.
- a. Pre-Billing Financial Assistance Review. Consistent with the procedure for the presumptive eligibility determinations above, accounts may be reviewed for financial hardship prior to initiation of the billing cycle. If a determination can be made that the account balance would create a financial hardship, a decision to award financial assistance for the amount due will be made. In addition, any other open existing self-pay balances, regardless of the amount due, will also be deemed financial assistance up to the date of the decision (but will not be subject to the refund provision above).
  - b. Pre-Collection Financial Assistance Review. Subsequently, accounts may be reviewed for financial hardship prior to transferring an account for collection. If a determination can be made that the account balance creates a financial hardship, a decision to award financial assistance for the amount due will be made and the account will not be transferred for collection. In addition, any other open existing self-pay balances, regardless of the amount due, will also be deemed financial assistance up to the date of the decision (but will not be subject to the refund provision above).
5. Medicare Bad Debt.
- a. Upon completion of the collection process, all Medicare Bad Debt eligible accounts should be reviewed for conversion from regular bad debt to Medicare Bad Debt.
  - b. Qualifying Medicare deductibles and co-insurance amounts are written-off directly to Medicare Bad Debt on accounts which have qualified for Medicaid or can demonstrate financial necessity through applying for Financial Assistance pursuant to the FAP.

6. UR and Contractual Write-offs.

- a. Accounts that do not meet Utilization Review criteria will be written-off at the time a Patient Fiscal Services Manager is notified. All write-offs must be approved by the Manager or by upper management.
- b. Contractual adjustment amounts are taken at or prior to the time payments are posted. These amounts are posted by the payment posters and do not require prior authorization from the Manager or upper management.
- c. Accounts which fail to meet the requirements of pre-authorization or other compliance with the terms of contracts with third party payers will be written-off to the appropriate write-off code and approved by the Manager or upper management.

7. Miscellaneous Write-offs.

- a. A Patient Fiscal Services Manager, the Director of Patient Accounting or other upper management must approve all other write-offs to bad debt. The reasons for these write-offs are varied and would include but would not be limited to billing errors, failure to comply with timely filing requirements, accounts with incorrect insurance information, etc.

8. General Information. The Patient Financial Services Department shall have final authority and responsibility for determining that Health System has made reasonable efforts to determine whether a responsible party is eligible for financial assistance and deciding that Health System therefore may engage in ECAs against the responsible party. More information about the FAP, this Policy, and the Patient Financial Services Department may be found:

- a. Online: [www.sheppardpratt.org/patient-care-and-services/resources/financial-support/](http://www.sheppardpratt.org/patient-care-and-services/resources/financial-support/)
- b. By Mail: Patient Financial Services Department  
Attn: Financial Assistance  
P.O. Box 6815  
Baltimore, MD 21285-6815
- c. In Person: All Patient Registration and Admissions Locations; or  
The Conference Center at Sheppard Pratt  
6501 N. Charles Street  
Baltimore, MD 21204
- d. By Phone: Call Customer Service at (410)-938-3370 or toll free at (800)-264-0949.

**References:**

**Attachments:**

**Revision Dates:**

**Reviewed Dates:**  
10/18

**Signatures:**

Armando Colombo: 10/09/18  
Harsh Trivedi: 10/04/18