DEPARTMENT:	**PATIENT FINANCIAL SERVICES**
SUBJECT	**CREDIT AND COLLECTION POLICY**
EFFECTIVE DATE:	**AUGUST 24, 2017**
REVIEWED DATE:	**JANUARY 1, 2022**
ISSUED BY:	**UNION HOSPITAL BOARD OF DIRECTORS**

PURPOSE: To establish an appropriate and consistent method for handling patient accounts, ensure patient access to appropriate financial counseling and charitable assistance.

PROCEDURE:

1. GENERAL CREDIT POLICY/PROCEDURE

1.1 It shall be the policy and procedure of Union Hospital (the "Hospital") to collect in full for all inpatient and outpatient services. Payment is due at the time services are rendered, with the exception of:

a. The portion of charges covered by:

1. A third party plan having a contractual agreement with the Hospital or

2. An assignment of insurance benefits to the Hospital;

b. A deferred payment plan approved by the Patient Financial Services Department;

c. A determination by the Patient Financial Services Department that a patient is unable to sustain the extraordinary burden of medical expenses due to limited income and resources as outlined in the Hospital's Financial Assistance Policy.

2. RESPONSIBILITY FOR IMPLEMENTING POLICY

2.1 The responsibility for implementing this Credit and Collection Policy (this "Policy") on a day-to-day basis shall be vested in the Director of Patient Financial Services. The director shall be responsible for interpreting and applying written policy, and properly training his/her employees' procedural applications and methodology. The director will also be

responsible for recommending policy changes relating to present and anticipated needs, and for assessing this Policy in relation to hospital objectives.

3. COLLECTION PROCEDURES

3.1 Patients who have not responded satisfactorily to the Hospital's efforts to determine his/her eligibility for Patient Financial Assistance and/or make arrangements for payment on an account within 150 days from the payment due date, may be referred for collection efforts.

3.2 The Hospital may engage in any of the following collection activities:

a. Automated dunning messages;

b. Form letters and personal letters;

c. Telephone calls;

d. Final notice statements;

e. Referral to a self-pay outsourcing service;

f. Referral to the hospital attorney

g. Referral to any Hospital-contracted collection services.

3.3 Extraordinary Collection Actions (ECAs) – The term "ECAs" is defined by Code Section 501(r) and its corresponding Treasury Regulations to include (but be not limited to) any actions that require a legal or judicial process. The Hospital, its collection agencies, and their respective representatives will not undertake any ECA until after reasonable efforts have been made to determine whether the individuals' accounts are eligible for assistance under the Hospital's Financial Assistance Policy. The ECAs that may be undertaken shall include, but not be limited to, the following:

a. Placing a lien on an individual's property;

b. Garnishing an individual's wages;

c. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus; and/or

d. Selling an individual's debt to a third party.

3.4 The Hospital may not engage in any of the following collection activities:

a. Foreclosure or sale of patients' (or the responsible parties') assets;

b. Use of body attachments; and/or

c. Garnishment of wages unless determination is made on individual cases that patient (or the responsible party) has sufficient income to satisfy the outstanding debt.

Other than activities specifically precluded by this Policy, the Hospital may engage in any actions, including ECAs (subject to the restrictions above), to obtain payment of a bill for medical care.

3.5 The Hospital may take an ECA involving a patient who fails to apply for Financial Assistance within 120 days from the date the first statement was made available to the individual but shall suspend any such ECA, pending a determination of eligibility, if the individual submits a Financial Assistance application within 240 days of such first statement.

3.6 The Patient Financial Services Department shall have responsibility for determining that the Hospital has made reasonable efforts to determine whether an individual is eligible for financial assistance and may therefore engage in one or more ECAs against the individual.

4. BAD DEBT WRITE-OFFS

4.1 Criteria for determining write-offs of accounts shall be one of the following.

a. A period of four months (120 days) without payment on the account unless approval for an extension is given by the Director of Patient Financial Services.

b. Repeated violations of contractual agreement with a pattern indicates a lack of proper intent on the part of the patient

4.2 Certain accounts that are written-off, but are known to be, or are believed to be collectible may be retained by the hospital or an independent collection agency for further follow-up.

4.3 The act of writing off an account will serve as permission to pursue ECAs, provided all provisions of Section 3 have been followed.

4.4 The Director of Patient Financial Services, utilizing the above criteria, will select accounts to write-off as bad debts. Upon approval of the Board of

Trustees, such accounts will be written off.

5. FINANCIAL COUNSELING AND PAYMENT PLANS

5.1 If a credit evaluation indicates the patient is financially unable to pay at the time services are rendered, a financial counselor may offer the patient/guarantor a deferred payment plan. Any such plan shall be reasonable in terms of the patient's ability to meet the payments and clearly understood and agreed to by the patient.

5.2 Any patient who expresses an inability to pay for services rendered due to lack of resources shall be referred to a financial counselor. All data pertinent to an evaluation of the patient's financial condition should be obtained so that a determination of eligibility for assistance may be made. A clear explanation of the Hospital's Financial Assistance Program will be made to the patient during the interview.

5.3 The Hospital's practice of providing financial counseling is limited to those efforts intended to recognize the amount owed to the Hospital for patient services and to determine alternate sources of payment.

6. ESTATES

6.1 The applicable county court will be contacted to determine the existence of a deceased patient's estate. Should an estate be in probate, the Director of Patient Financial Services will have the option of filing a claim within sixty (60) days from publication of the estate notice.

7. THIRD-PARTY LITIGATION

7.1 The Hospital will regard the patient as being responsible for payment of his/her account in a situation in which the main source of payment is potential recovery from litigation between the patient and a third-party.

8. BANKRUPTCIES

8.1 A creditor's claim will be filed immediately with the referee in bankruptcy unless there are no assets to be distributed. Accounts of patients which have been listed on a legally declared bankruptcy petition will be written off, but the account will not be given to an outside collector or attorney.

8.2 Should an account have been written off to an outside collector or attorney, notification of bankruptcy with request to cease collection activity will be forwarded to the appropriate collector/agency.

9. COUNTERSUITS

9.1 The processing of statements to patients will not be altered under the threat or possibility of a countersuit by the patient; the two issues will be regarded as being separate. However, if the patient threatens or implies the possibility of a suit against the Hospital, the Director of Patient Financial Services shall be notified and shall seek legal advice as to the claims.

10. OVERPAYMENTS/CREDIT BALANCES

10.1 Overpayments on patients' accounts occur as a result of duplicate insurance payments, payments by both primary and secondary insurance carriers, or payments by patients and their insurance carriers. The Hospital's role does not include coordination of benefits between insurance carriers and patients.

a. Checks resulting in overpayments on paid-in-full patient accounts received from insurance companies (other than Medicaid, Medicare) shall be returned to the payer, unless overpayment resulted from a prior patient payment, whereupon overpayment would be refunded to the patient.

b. Checks resulting in overpayments received from patients on paid-in-full accounts shall be returned to the patient only if the patient does not have any other outstanding balances with the hospital.

c. Payments received from insurance companies (other than Medicaid, Medicare) or patients on patients' accounts with a balance less than the payment amount will be accepted and posted to the appropriate account. A refund will then be issued to the payer for the amount of the overpayment.

d. Medicare or Medicaid overpayments will be processed through adjustment billings.

e. Refund attempts made to patients who cannot be located after diligent effort will result in those amounts being adjusted from Accounts Receivable in accordance with the State of Indiana Unclaimed Property Statutes.

f. Overpayments will be returned to the patient or to the appropriate insurance carrier within 60 days of receipt on average.

11. PROMPT PAY DISCOUNTS

11.1 Prompt pay discounts will be offered to all accounts with self-pay balances with the following conditions:

a. The discount will be 20% of the self-pay balance.

b. The discount will be granted if receipt of the entire self-pay balance is received on or before the first statement due date.

12. NO CHARGE FOR ADVERSE EVENTS

12.1 The Hospital is committed to delivering safe care. On the rare occasion when a serious, adverse event that could have been prevented occurs, the Hospital has undertaken a variety of strategies to support the injured patient and his or her family, including not charging the patient for the costs of care related to the event. Based on principles adopted by the American Hospital Association and the Indiana Hospital Association, the Hospital will not expect payment from patients or their insurers or employers for care related to preventable serious, adverse events.

12.2 The Hospital continues to strive to put preventive systems in place and make the changes necessary to keep patients safe from harm. Unfortunately, human error can and does occur. In the rare cases when patients are harmed, we must do the right thing for those patients and their families. Information about serious, adverse errors should be quickly and openly communicated to patients and their families. And, the purchasers of those health care services - patients, insurers or employers should not be charged for that care. The following principles, which specifically describe the types of errors for which the Hospital will forego payment are:

a. **The error or event must be preventable.** Where there are practices that are effective in preventing a particular harm from occurring, and they could have been implemented by the Hospital, the error or event would be considered preventable. The Hospital should not be held accountable for an occurrence that it could not reasonably prevent. A root cause analysis may be required to determine preventability.

b. **The error or event must be within the control of the Hospital.** Errors that may have occurred in the manufacture of drugs, devices or equipment, well before the materials reached the Hospital’s doors, are examples of events that would be outside of the Hospital’s control. A root cause analysis may be required to determine the source of the error.

c. **The error or event must be the result of a mistake made in the Hospital.** These include errors in which the hospital failed to successfully carry out a practice that would have, in all probability, prevented harm to the patient.

d. **The error or event must result in significant harm.** The events will be limited to those that yield very serious results.

e. **Any process for identifying non-payable events will incorporate a case-by-case review and determination.** While the sources and cause of some adverse events may be clear, most would require further investigation and a root cause analysis to determine the cause of the adverse event and to assign ultimate accountability.

12.3 The following 11 specific events may be considered preventable:

a. Surgery performed on a wrong body part;
b. Surgery performed on a wrong patient;
c. The wrong surgical procedure performed on a patient;
d. Unintended retention of a foreign object;
e. Patient death or serious disability associated with air embolism that occurs while being treated in a hospital;
f. Patient death or serious disability associated with a hemolytic reaction to the administration of incompatible blood or blood products;
g. Stage 3 or 4 pressure ulcers acquired after admission;
h. Patient death or serious disability associated with a fall or trauma after admission;
i. Patient death or serious disability associated with catheter-associated urinary tract infections;
j. Patient death or serious disability associated with vascular catheter-associated infection;
k. Patient death or serious disability associated with a medication error.

12.4 In addition to the preceding 11 events.

a. If a re-admission is caused by a preventable serious adverse event that occurred at the Hospital, then the Hospital will not seek payment for services directly related to that event.

b. If an additional procedure is performed to correct a preventable serious adverse event that occurred during a previous procedure, the Hospital will not expect payment for charges related to that additional procedure.

c. If a preventable serious adverse event results in an increased length of stay, level of care, or significant intervention, the Hospital will do its best to separate those additional charges and either not bill them initially or make adjustments to the bill with the payer or patient as soon as possible. Additionally, in the case of payers using the DRG system, if the preventable serious adverse event results in a higher DRG, adjustments will be made to bill for the lower DRG.

d. If there are extenuating circumstances or uncertainty that a preventable serious adverse event occurred, determination of any payment adjustment will be made on a case-by-case basis.