A. **SCOPE:**
   Rutland Regional Medical Services

B. **PURPOSE:**
   To establish protocols and procedures for processing a hospital bill for a patient (whether insured, underinsured, or uninsured), following up once a bill has been issued to the patient, and if necessary, transferring the account to an outside collection agency (OCA). Rutland Regional is committed to providing medically-necessary care to all patients regardless of their ability to pay, and satisfaction of debts will be determined by financial status, the organization’s ability to accept payment plans, and the patient’s cooperation.

C. **POLICY:**
   Patients are responsible for the cost of services received. Rutland Regional will bill the patient’s health insurance carrier(s) for them, as long as a valid I.D. card and/or information regarding insurance coverage is presented at the time of registration. Rutland Regional maintains an active follow up program with all health insurance carriers. Unpaid balances, including all applicable co-payments, deductibles, co-insurances and any non-covered services are the responsibility of the patient. Rutland Regional staff will attempt to collect these owed amounts by mailing statements, making phone calls, and taking payments at the time of service. Payments may be made via cash, credit card, personal checks and money orders.

Killington Medical Clinic is a seasonal (winter skiing) department of Rutland Regional Medical Center. The majority of their patient base comes from out-of-state and/or out-of-country. Therefore, Killington Medical Clinic will be a self-pay facility for all uninsured patients and out-of-country patients, as well as, any supply purchases. Rutland Regional will submit claims on behalf of a patient to both contracted in-network third party insurances and out-of-network insurances.

For future non-medically necessary elective visits, it will be the responsibility of Rutland Regional to obtain either a pre-authorization from the appropriate payer or to contact the patient by phone and/or mail to arrange pre-payments and/or a sufficient payment plan which would provide assurances that Rutland Regional would get full payment for services to be rendered. Without such arrangements, Rutland may contact the ordering physician’s office to defer or cancel the scheduled visit.
Self-pay patients who are admitted to the hospital from the Emergency Department will be visited by a Financial Counselor so they may assist the patient with FAP and/or Medicaid enrollment.

An automatic 10% uninsured discount will be applied to all self-pay encounters. An additional prompt pay discount of 20% can be offered to uninsured patients if the visit is paid within 30 days of the first billing statement. These discounts do not apply to anyone who has insurance and discounts can be reversed if Rutland Regional learns insurances were in effect at the time of service. The patient can contact the Financial Counselors at 802.747.1648 to coordinate this prompt pay discount.

Additional bills may be sent to patients from physicians not employed by Rutland Regional. These bills are for professional services rendered by those doctors in radiology, pathology, oncology, anesthesiology, and your local Primary Care Provider(s). The Rutland Regional price estimate does not cover any of these services for the following physician groups. The physician groups can be reached at the telephone numbers listed below:

- Foley Cancer Center
  - Allan Eisemann, MD 800-367-4521
  - University of Vermont Medical Center for Rick Lovett, MD 800-639-2719
- Laboratory
  - Mid Vermont Pathology 855-874-1596
- Diagnostic Imaging
  - Rutland Radiologists 802-770-5172
- Anesthesiology
  - Sheridan Healthcare of Vermont 800-296-2611
- Your Local Primary Care Provider(s)

Upon request, a list of those providers covered under the FAP can be provided.

Accounts are considered bad debt and are transferred to an outside agency for collection, when 1) attempts to collect the debt have been unsuccessful; and 2) patient has been offered (and has been denied or fails to return application for) assistance under Rutland Regional’s Financial Assistance Policy (FAP).

D. DEFINITIONS:

- Advanced Beneficiary Notice (ABN): also called a “waiver of liability” – is a notice that Medicare providers and suppliers are obligated to give to an Original Medicare enrollee when they find that Medicare does not cover the services the enrollee requests.
- Amounts Generally Billed (AGB): AGB is the average amount paid by all private health insurers, Medicare, and Medicaid for emergency or other medically necessary patient services. Rutland Regional uses the “look back method” as defined in section 501 (r) (5) (b)
(1) of the Internal Revenue Code. Rutland Regional will limit amounts charged for
emergency or other medically necessary care provided to individuals eligible for assistance
under this policy to not more than AGB. Rutland Regional will update the AGB annually.
For FY2014 the AGB discount is 52.1%. The AGB will be updated annually within 120 days
of Rutland Regional’s fiscal year end.

- **Annual Out of Pocket Maximum:** The maximum amount a patient is responsible to pay for
  services received at Rutland Regional each year. If patient is FAP-eligible, this amount will
  not exceed 20% of the household income which is consistent with the definition of
catastrophic encounters.

- **Application Period:** the period during which the hospital accepts and processes FAP
  applications. This period begins with the date of the first post-discharge billing statement and
  ends 240 days after Rutland Regional provides the individual with their first post-discharge
  billing statement.

- **Authorized Representative:** you can give a trusted person permission to talk about the
  Vermont Health Connect application, your information, and act for you on matters related to
  the Vermont Health Connect application.

- **Bad debt** means a debt that is not collected and is worthless to the creditor.

- **Catastrophic Encounter:** A balance owed by a patient that exceeds 20% of the patient’s
  household income.

- **Charged:** only the amount the FAP-eligible individual is personally responsible for paying,
  after all deductions, discounts (including discounts available under the FAP), and insurance
  reimbursements have been applied.

- **Co-insurance** means the percentage of total charges that a person is required by their
  insurance to pay out-of-pocket.

- **Commercial Payer:** any insurance payer other than a State or Federal Insurer such as
  Medicare or Medicaid. Examples: BCBS or MVP.

- **Contractual Adjustment** means a discount as a result of the contractual arrangement with an
  insurance carrier. Rutland Regional will bill most insurances (exception: Killington Medical
  Clinic and their out-of-country patients) and does not have a contract with all insurances.

- **Copay** means a set fee for services that a person must pay at each visit. The amount of the
  copayment is determined by the person’s health insurance carrier;

- **Creditor:** Is a person or organization to which money is owed by a debtor (Rutland Regional
  is a Creditor).

- **Debtor:** Is a person who owes a creditor; someone who has the obligation of paying a debt
  (Rutland Regional’s customers are debtors).

- **Extraordinary collection actions (ECA):** ECAs are actions taken against the patient related to
  obtaining payment of a bill for care covered under Rutland Regional’s FAP that require a
  legal or judicial process or involve selling an individuals’ debt to another party or reporting
  adverse information about the individual to consumer credit reporting agencies or credit
  bureaus. Examples of ECAs include, but are not limited to: place a lien on an individual’s
  property; foreclose on an individual’s real property; attach or seize an individual’s bank
  account or any other personal property; commence a civil action against an individual; cause
  an individual’s arrest; cause an individual to be subject to a writ of body attachment; and
  garnish an individual’s wages.
• Financial Assistance Program (FAP): A charity care program providing access to those without the ability to pay and to offer a discount from billed gross charges for those who are able to pay a portion of the costs of their care.

• Federal Poverty Guidelines (FPG): a simplified calculation of the official poverty population statistics used for administrative purposes, such as, determining financial eligibility for programs.

• Guarantor means an adult receiving medical services, or the parent of a minor child (under age 18) receiving services who signs the consent for medical treatment on their behalf (not the subscriber of insurance).

• Household: all family members or cohabitants residing in the same home.

• Income: Gross earnings, unemployment compensation, workers compensation, social security benefits, supplemental security income, public assistance, veteran’s benefits, survivor benefits, pension or retirement, interest, dividends, rents, royalties, estate income, trusts, educational assistance, alimony, annuities, and child support for a household.

• Income-eligible means a person who meets the financial criteria according to Federal Poverty Guidelines and who qualifies for particular Medicaid programs (as outlined below).

• Indigent means poor or destitute.

• Insurance Deductible means an amount a person must pay for healthcare expenses before insurance covers the cost; often based on a yearly amount.

• Liquid Assets: any asset that is cash or can be easily converted to cash such as cash, checking and savings accounts, money markets, and CD’s.

• Look Back Method: a calculation used to average the amount billed over the prior 12 months to Medicare patients for a given service or the average amount billed over the same period to Medicare patients and all private health insurers.

• Medically Indigent: Health insurance coverage does not provide full coverage for all of the medical expenses and the self-pay unreimbursed medical expenses, in relationship to family income, would make the patient indigent if the patient were required to pay full charges for the medical expenses.

• Medically Necessary: health services and supplies that under the applicable standard of care are appropriate: (a) to improve or preserve health, life, or function; or (b) to slow the deterioration of health, life, or function; or (c) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness or injury.

• Medicare Low Income Beneficiaries Limitation: recipients with liquid assets limited to $7,160 for a single person and $10,750 for married couples.

• Notification Period: the period during which Rutland Regional must notify an individual about the FAP. The period begins with the date of the first post-discharge billing statement and ends 120 days later.

• Outside Collection Agency (OCA): a company hired by Rutland Regional to collect a debt that is owed.

• Prompt Pay Discount: Rutland Regional will provide a 20% prompt pay discount for any uninsured visit paid with 30 days of the first billing statement.

• Reasonable Collection Efforts: Notification to an individual about our FAP; in the case of an individual who submits an incomplete FAP application, we will provide the individual with information relevant to completing the FAP application; and in the case of an individual who
submits a complete FAP application, we will make and document the determination as to whether the individual is FAP eligible.

- **Underinsured patient**: a patient that is exposed to significant financial losses due to inadequate health insurance coverage.
- **Uninsured patient**: a patient who is not covered under a medical insurance plan.

### E. PROCEDURE:

**Billing**

In lieu of full payment for all charges Rutland Regional will submit claims to insurers. The following insurances will be billed by the hospital:

1. Medicare
2. Medicaid
3. Blue Cross
4. Workers’ compensation
5. HMO/PPO
6. CHAMPUS
7. Various commercial carriers (in-network and out-of-network)

If a patient chooses (or is required) to bill his/her own insurance, the hospital will provide an itemized statement to the patient, but will treat the account as self-pay. All inpatient and outpatient services that require precertification must also be authorized prior to service being rendered. If Rutland Regional has a contractual agreement with the insurance company, Rutland Regional will attempt to obtain the prior authorization. If Rutland Regional is not contracted with the insurance, the patient will be responsible for ensuring that the authorization is in place prior to the date of service or will be billed for the services.

Our billing department processes claims, either electronically or by paper (depending on insurser), and billers review accounts on a regular basis. The biller will work any denials, requests for additional information, late charges and will do so within the timely filing limits by payer. If there is a secondary insurance held by the patient, we will also bill the secondary (or even third or more “tertiary”) insurance. Once an insurance company has processed the claim and all payment sources have met their payment obligations, the patient will be billed the remaining balance, if any.

Remaining balances may include:

- copay
- coinsurance
- deductible
- non-covered charges

There are numerous reasons why insurance may deny for coverage, ranging from lack of patient information, how a claim was submitted, pre-authorization issues, etc. Rutland
Regional also reserves the right to bill a patient directly if their insurance company is unresponsive, or particularly slow in making payment. Insurers may also audit a claim, and if they later determine that payment was made in error, they may recoup payment. If it is determined that the charges are due from the patient, Rutland Regional will bill the balance to the patient.

Rutland Regional does not become involved in third party liability cases, and it is the patient’s responsibility to ensure that their bill is paid promptly, regardless of any pending litigation resulting from an injury caused by a third party. In lieu of collection action in a liability case, however, patients may opt to permit Rutland Regional to file a hospital lien against a potential settlement.

The billing process can be complicated and involves constant follow up, may involve appeals, as well as credits/refunds to insurance companies as well as to patients if a patient pays on an account when the insurance should have processed. Ultimately, unpaid balances, including all applicable co-payments, deductibles, and any non-covered services are the responsibility of the patient. Delinquent accounts will be subject to collection action as described below.

Billing questions can be referred to a Financial Counselor at 802.747.1648. Patients making payments or developing a payment plan can call Customer Service at 802.747.1751. To pay your bill on line, please visit us at [http://www.rrmc.org/patient-visitors/paying-your-bill/](http://www.rrmc.org/patient-visitors/paying-your-bill/).

**Collections**

The collection of a debt begins soon after patient receives their first statement (once insurance has processed or sooner if patient is uninsured) and the following is a timeline of the statement cycle:

**Day 1**  
the day the encounter becomes the patient’s responsibility (self-pay) and an itemized bill is generated and it includes all specific charges, insurance payments, and contractual adjustments (if applicable);

**Day 30**  
if first statement remains unpaid, a reminder statement is generated (without detail);

**Day 60**  
if second statement remains unpaid, a reminder statement is generated;

**Day 90**  
if third statement remains unpaid, a reminder statement is generated along with a “final notice” indicating the encounter will be transferred to a collections agency if payment is not received.

**Day 120**  
FAP Notification Period ends and encounter will be transferred to a collection agency unless FAP eligible information has been received from patient.
Day 240 FAP Application Period ends.

Hospital care will not be denied to any person solely on the basis of their ability to pay; however, indigent patients will be referred to Financial Counselors. Rutland Regional does not engage in “extraordinary collection actions” (“ECAs”) before making “reasonable collection efforts” to determine whether the individual is eligible for assistance under Rutland Regional’s FAP.

ECAs are actions taken by Rutland Regional against the patient related to obtaining payment of a bill for care covered under Rutland Regional’s FAP that require a legal or judicial process or involve selling an individuals’ debt to another party or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

“Extraordinary collection actions” include, but are not limited to:
1. Place a lien on an individual’s property;
2. Foreclose on an individual’s real property;
3. Attach or seize an individual’s bank account or any other personal property;
4. Commence a civil action against an individual;
5. Cause an individual’s arrest;
6. Cause an individual to be subject to a writ of body attachment; and
7. Garnish an individual’s wages.

ECA will discontinue when:
There is any indication that an application for financial assistance has been received, the patient’s accounts will not be subject to further collection action for 240 days from initial statement or if an incomplete application has been received. The Financial Counselor will send the patient a written notification indicating what is still required back to Rutland Regional within 30 days noted in letter. A plain language summary of the FAP will be included with the letter. ECA’s will be suspended until determination of FAP eligibility is completed. However, if notification of required documentation is mailed to patient at the end of the application period (prior to 240 days from first billing statement sent to patient) Rutland Regional will not begin ECA’s until day 270 days from first billing statement.

“Reasonable collection efforts” include:
1. Notification to an individual about our FAP;
2. In the case of an individual who submits an incomplete FAP application, Rutland Regional will provide the individual with information relevant to completing the FAP application; and
3. In the case of an individual who submits a complete FAP application, Rutland Regional will make and document the determination as to whether the individual is FAP eligible.
Approved FAP:
Once FAP application is received and approved, all ECA’s will be suspended and any ECA actions taken will be reversed. Rutland Regional will document determination in health information system. A written notification will be sent to the patient notifying them of FAP eligibility decision, FAP eligibility timeframe, and their financial responsibility. Monthly billing statements will be sent to the patient if there are remaining balances owed along with contacts to obtain information on AGB and how the amount owed was determined. Any payments made by the patient within the application period will be refunded.

Denied FAP:
Once FAP application is denied because patient does not meet the eligibility guidelines or the patient did not send Rutland Regional the required additional documentation to complete the application within the 30 day notification, a letter will sent to the patient notifying them that they were denied and ECA’s will resume if payment is not made.

The Collection Manager or designee will utilize their discretion, as well as the following system tools, to determine if an account should be moved to an OCA:

1. Access the Revenue Cycle module of our Cerner Health Information System (HIS) and review the following:
   a. Comments - Review all staff notes, including billing/insurance issues, returned mail/address issues, patient concerns (current and past), hospital liens, probate and bankruptcy status, etc. (see Probate policy and Bankruptcy policy)
   b. Payments – Review all patient payments and payment history for all active encounters.
      i. Review whether prior patient payments have been applied to the balance, there has been 60 days since the last payment, and the patient has been sent a final notice letter;
      ii. Certify that payments are within Rutland Regional guidelines in accordance with current Payment Plan policy;
      iii. Certify that previous regular payments have not established a payment plan based on performance according to the Fair Debt Collection Practices Act;
   c. Formal Payment Plan (FPP) – If a FPP has been established with the patient, review comments with regard to both verbal agreements, and follow up written correspondence, as it relates to payment plan start date and monthly amounts.
   d. Statements – Review that at least four (4) statements have generated, as outlined above, and there has been 120 days from the date of the itemized bill to its placement on the collections preview work queue.
      i. Each statement must indicate a status of “submitted”;
      ii. Open at least one statement to verify an address is shown when guarantor is different than patient;
iii. Verify that sufficient attempts have been made to update and correct a patient’s mailing address if statements are being returned due to an insufficient or incorrect mailing address (see Returned Mail policy);

iv. If bills are returned and a corrected address cannot be obtained, the debt can be referred to an OCA before all four (4) statements have been generated. Exception: Patients with Medicare as primary insurance cannot be referred to an OCA prior to 120 days from date of service.

v. Insurance and billing - Review insurance payments, if applicable, to check that patient’s balance (coinsurance, deductibles, or notes re: denials) is accurate.

vi. Guarantor assignment – Review for appropriate Guarantor status, as defined above, particularly in cases of where the patient is a minor child. The organization cannot enforce divorce decrees and considers these documents an agreement between the divorcing parties and the court system.

e. Invoices – bills sent to Rutland Regional business clients who request services for their employees will be mailed an invoice once a month. If client invoice bills that are not paid timely (6 months) they may be transferred to an OCA and/or services will end if all attempts to contact the client for payment arrangements have been unsuccessful.

2. If patient is uninsured, access the Vermont Medicaid website and review for patient coverage:
   a. If patient was eligible for the following Medicaid programs within the application period (240 days from first bill mailed to patient), the patient is considered “income-eligible” by Rutland Regional, and the encounter balance will either be billed through the retroactive service Medicaid application process or can be adjusted under the FAP. These are the Medicaid categories covered.
      1. Medicaid Managed Care
      2. Traditional Medicaid
   b. Complete FAP checklist form, and submit for final approval.

3. Once approved, self-pay customer service staff will adjust the respective encounter(s) for eligible write-off.

If the above conditions are met, and the account balance is ready for transfer to and outside collection agency, the following guidelines shall be followed:

1. If the patient’s remaining balance, after insurance (if applicable),
   a. is less than $10,000.00, the Financial Counselor may transfer the account to an OCA at his/her own discretion (and as per guidelines above);
   b. is between $10,000.00 and $50,000.00, the Collection Manager will be provided a printout of the account comments and payment history information for written approval and signature;
c. is between $50,000.00 and $100,000.00, the Patient Financial Services Director will be provided a print out of the account comments and payment history information for written approval and signature;
d. is greater than $100,000.00, the Financial Counselor will print the account comments and payment history information, and seek written approval and signature from the Chief Financial Officer (CFO) by providing information to Collection Manager.

2. All printed, approved, and signed account histories for those balances over $20,000.00 will be kept in a binder by the Financial Counselor or designee for a minimum of seven (7) years.

3. Once reviewed and/or approved, the Collection Manager or designee will transfer/assign the encounter to an OCA.

4. Accounts sent to an OCA are kept in the Cerner HIS, and can be accessed via the Discern Explorer/ProFit Reports/Follow Up and Collections/Encounters to Coll Agency Detail EXCEL report.

Collection questions can be referred to the Collection Manager at 802.747.1629.

EDUCATION:

All Patient Financial Service staff that has direct contact with our customers is required to read and sign that they have read and understand the policy.

MONITORING/RECONCILING:

Billing
1. Daily - Patient Accounting Representatives monitor work queues for follow up with patients and/or insurers;
2. Monthly – PFS leaders monitor biller backlog through the use of the Aged Trial Balance (ATB) reporting tool and review of individual work queues;
3. Monthly – PFS leaders use AR Analysis and Billing Adjustment Reports to monitor discrepancies and to produce their Month-End report to the Revenue Cycle Leaders.

Collections
1. Daily - Financial Counselor will review the collection preview queue to verify that the above conditions are met prior to transfer to an outside agency.
2. Monthly – Collection Manager or designee will
   a. Reconcile acknowledgment reports provided by the OCA to ensure all account balances match. Any discrepancies will be reported back to the OCA.
   b. Manage the OCA recall cycle.
OTHER POLICIES AND FORMS:

1. Payment Plan Policy
2. Return Mail Policy
3. Financial Assistance Program Policy
4. Hospital Lien Policy
5. Probate Filing Policy
6. Bankruptcy Filing Policy
7. Medicare Cost and State Report Policy
8. Notify Patients Regarding the Financial Assistance Program Policy

REFERENCES AND BIBLIOGRAPHY:

2. 42 CFR 413.89 Bad debts, charity and courtesy allowances
3. Medicare Provider Reimbursement manual, CMS Pub 15, Part 1, Ch. 14 304-326
4. Patient Protection and Affordable Care Act of 2010 – Section 501(r)(6)
5. Federal Register, Vol. 77 No. 123
6. Internal Revenue Code Section 501 (r) and Treasury Regulations 1.501(r) et seq
7. RRMC EMTALA-Medical Screening and Stabilizing Treatment Policy