PURPOSE:

Crossing Rivers Health is committed to providing patients with the highest quality of care and working to ensure that patients are presented with payment options that are sensitive to their financial situations and provide ample opportunity to resolve balances in a timely manner. In the event that patients do not fulfill their financial obligations in a timely fashion, an external agency may be called upon to assist with and expedite collections.

POLICY:

At the time of patient presentation, Crossing Rivers Health will gather demographic and insurance information that supports the timely generation and release of insurance claim forms and /or self-pay statements for services rendered. Subject to compliance with the provisions of this policy, Crossing Rivers Health may take any and all legal actions, including Extraordinary Collection Actions (ECA's), to obtain payment for medical services provided. Crossing Rivers Health will not engage in ECA's, either directly or by any debt collections agency or other party to which the hospital has referred the patient's debt, before reasonable efforts are made to determine whether a Responsible Individual(s) is eligible for assistance under the Community Free Care program.

DEFINITIONS:

Bad Debts: Bad debts are claims arising from rendering healthcare services to a patient that the hospital, using sound credit and collection policy, determined to be uncollectible from patients who have the ability to pay.

Contractual Allowances/Discounts: Contractual allowances/discounts are the excess of the hospital's normal charge for healthcare services over the payment received from third party payors under contractual agreements.

Policy Discounts: Differences between revenue recorded at established rates and amounts realizable for services.

Community Free Care: Community free care are charges for healthcare services that are written off based on the hospital community free care policy. A claim can be considered community free care after an investigation of the patient's ability to pay, including non-qualification for a government program. Community free care does not include any of the following: Medicare Bad Debts, Contractual Allowances/Discounts, and Policy Discounts.

Extraordinary Collection Actions (ECAs): Any action against an individual responsible for a bill related to obtaining payment for a self-pay balance that requires a legal or judicial process, such as commencing a civil action, garnishing wages, leans or reporting adverse information about the Responsible Individual to consumer credit reporting agencies/credit bureaus. ECA's do not include transferring of a self-pay balance to another party for purposes of collection without the use of ECAs.

Responsible Individual(s): The patient and any other individual(s) having financial responsibility for a self-pay balance.

Self-Pay Balance: The portion of a patient account that is the individual responsibility of the patient or other Responsible Individual.

PROCEDURE:

1. Billing
   - A. In order to maintain familiarity and understanding of the patient's account, each Business Associate is assigned a section of the alphabet. The Business Associate follows the patient from admission, for inpatients, or initial billing through the final settlement of the account.
   - B. Itemized Bills: Sent to insurance, worker's compensation, and private pay patients, upon request.
     - 1) If the patient has insurance coverage, the designated Business Associate will submit each claim to the patient's insurance company, either by electronic submission or by mail.
     - 2) If the patient is classified Private Pay, a first time summary bill will be mailed to the patient or their guarantor within 30-40 days after discharge. The first time bill states patient responsibility. An itemized bill is sent upon request.
   - C. Monthly Statement: Sent on a cycle basis. This procedure is repeated approximately every thirty (30) days until the account is paid, considered uncollectible, sent to early out, or written off.
2. Collection
   - A. Prior to Discharge: Every admission to the hospital must have the responsible party sign a Statement of Financial Responsibility.
   - B. Upon Inpatient or Discharge of Outpatient: Attempt to collect WI MA co-pays. If the patient has insurance, collect the amount estimated that will not be paid by the insurance. In outpatient charges, attempt to collect WI MA co-pays, hearing aids, batteries, and any other over-the-counter items owed, regardless of the situation.
   - C. After Discharge or Outpatient Charges: Follow the billing procedure first with the patient bills, then with the monthly statements as follows:
     - 1) Patient accounts with no insurance coverage – After following the billing procedure with accounts where there was no payment or other action, each step is noted by the Business Associate starting here:
       - a. 1st Monthly Statement – Approximately 30 days – send statement.

b. 2nd Monthly Statement – Approximately 60 days – send statement with appropriate message.

c. 3rd Monthly Statement – Approximately 90 days – send statement with appropriate message.

d. Account is sent to Early Out program.

e. The Early Out program will work the account for 30 days. If Early Out is unsuccessful in setting up an acceptable payment plan, the account will be presented back to the hospital for approval of collection write-off.

f. Accounts are listed for Collection Write-Off – The report lists the patient's account number, name, date of write-off, and amount of write-off.

g. The report is presented to the Chief Executive Officer, Chief Financial Officer, and Board of Directors at the next Board meeting.

2) Patient accounts with insurance coverage if insurance pays and there is a balance due:

a. 1st Monthly Statement shows the total amount of the bill, how much the insurance paid, and the balance due from the patient.

b. 2nd Monthly Statement (if there is no payment received) is sent out with balance due. All action taken from this point on is noted by the Business Associate.

c. 3rd Monthly Statement (if there is no payment received) is sent out with balance due.

d. Account is sent to Early Out program.

e. The Early Out program will work the account for 30 days. If Early Out is unsuccessful in setting up an acceptable payment plan, the account will be presented back to the hospital for approval of collection write-off.

f. Accounts are listed for Collection Write-Off – The report lists the patient's account number, name, date of write-off, and amount of write-off.

g. The report is presented to the Chief Executive Officer, Chief Financial Officer, and Board of Directors at the next Board meeting.

3) Patient accounts with insurance coverage if insurance does not pay and/or sends a rejection notice:

a. 1st Monthly Statement – Make note that insurance has either denied the bill or has not responded to the claim. If the latter occurs, follow up with insurance company by telephone to check on status of claim. Send monthly statement to patient with note that we have not heard from their insurance company – please contact them.

b. 2nd Monthly Statement – If there has been no payment or other action on the account, all action taken from this point on is noted by the Business Associate. Follow Collection Procedure for patient accounts with no insurance coverage starting with 2nd Monthly Statement.

D. On an ongoing basis, Business Associates will monitor patients who consistently do not pay their bills and yet are regularly visiting the hospital. The Business Associates will keep the Business Office Director apprised of problem situations. The Business Office Director will be responsible for informing appropriate persons.

3. Financial Arrangements – Credit Policy

A. Financial Arrangements – Following is a guide for establishment of a payment schedule for accounts.

B. Balances are to be paid in full within 24 months

Payment Plan Guidelines:

Amount Owed	Payment Expected
$0 - $100	$10 per month
$100 - $200	$20 per month
$200 - $500	$50 per month
$500 - $1000	$100 per month
$1000 or greater	10% of balance or to be paid in full within 24-months

If patient fails to follow through on their monthly payment agreement: each step taken is noted by the Business Associate.

1) 1st Monthly Statement – Business Associate will remind the patient that regular monthly payments are necessary.

2) If no payment is received, account is sent to Early Out program.

4. General Credit Policy – Try to get the responsible party to agree to a specific payment plan. If patient states no payment can be made at this time, allow one (1) to three (3) months grace, depending on the situation. Patient must contact us at that time to inform us of the status.

5. Community Free Care – A patient can apply for community free care. See Criteria and Plan of Action for Patient Unable to Pay policy.

6. Write-Off Procedure – Accounts reviewed by the Business Associate, Patient Accounts Manager, Business Office Director, or Chief Executive Officer that are deemed uncollectible are reported as follows; reviewed by the Chief Financial Officer and Business Office Director; and then presented to the Board of Directors for approval every month.

A. Accounts to be written off to the Collection Agency, Complete and Final Write-Offs (Plain), Bankruptcy, and Community Free Care Write-Offs are listed separately.

B. The report lists the patient's account number, name, date of write-off, and amount to be written off, as well as the type of write-off.

C. The Patient Accounts Manager shall note on each patient billing the amount written off, date of write-off, and type of write-off.

D. These written-off accounts will be segregated in files listed under "Free Care", "Plain" (Complete), and "Collection" Write-Offs.

E. The standard small balance write off shall be anything $5.00 and less.

7. Other Items

A. Record insurance rejections, effective dates of bankruptcy, and patient agreements to pay in the computer under the patient's account. Each entry is dated and initialed by the individual concerned with the action taken.

B. Check accounts in computer by Guarantor including Collection Write-Offs before signing a receipt "Paid in Full" or accepting a check marked "Paid in Full".

C. Crossing Rivers Health will make a reasonable attempt to collect deductibles and copayments from all patients.

D. Business Associates will track claim denials on a report and submit monthly to the Financial Services Associate. Denials will be sorted by reason, biller, and department. Supporting documentation will be given to the Business Office Director. The Patient Accounts Manager and/or Business Office Director will review accounts prior to write-off.

Implementation and Review

The Business Office Director has the responsibility for determining that the facility has made reasonable efforts to determine whether an individual is eligible for free care and may therefore engage in ECAs. The Business Office Director for Crossing Rivers Health has authority to review and approve accounts recommended for collection activity. A report of accounts placed with the external collection agency will be submitted to the Business Office Director for Crossing Rivers Health for documentation of approval. The authority to review, approve accounts recommended for collection activity, and documentation of the approval will be the responsibility of the Business Office Director of the Crossing Rivers Health.

Obtaining Additional Information

Information regarding and copies of the Community Free Care policy or application, can be obtained by:

1. Requesting in person at Crossing Rivers Health
2. Contacting your representative directly at the Crossing Rivers Health Business Office or at the general number - 608-357-2000.
3. Accessing Crossing Rivers Health website at: www.**crossingrivers**.org
4. Submitting a written request to Crossing Rivers Health, 37868 US Highway 18, Prairie du Chien, WI 53821