THE GRIFFIN HOSPITAL
STANDARD OPERATING POLICIES

SUBJECT: FREE BED FUNDS/UNINSURED PROCESS/FREE CARE ASSISTANCE

EFFECTIVE DATE: 7/2011 SUPERCEDES: 1/2010

RESPONSIBLE DEPT: Business Services APPROVED BY:

Administrator

POLICY:

The following policy represents Griffin Hospital's policies and procedures for Free Bed Funds, Uninsured Patients, and Free Care Assistance. All three policies identify funds available for patients having services provided at Griffin Hospital who do not have any type of medical insurance on service date.

PROCEDURES:

Free Bed Funds:

1. Griffin Hospital has published a Free Bed Pamphlet that is located in all patient registration work stations. The pamphlet is outlined in both English and Spanish (see attached sample).

2. The Free Bed Pamphlet is available to all patients admitted to or registered at Griffin Hospital.

3. The pamphlet identifies to the patients the Griffin Hospital Free Bed Funds and the criteria for qualifying for the funds. Free Bed Funds available are:

   - The Eno Fund: an applicant must be a worthy Protestant woman over 60 years old and reside in the town of Ansonia, Derby or Seymour.
   - Pine Trust: available to indigent patients of Griffin Hospital who reside in the City of Ansonia.
   - DN Clark Fund: available to Shelton residents proving financial hardship.

4. To apply for Free Bed Funds, the patient will meet with the hospital Financial Advisor to complete the Free Bed Fund Application.

5. All patients who are seen by the Financial Advisors are required to sign off on the Free Care/Free Bed Informational Letter (attached).

12-028-AR

6. A monthly report will be maintained for each Free Bed Fund by the Collection Supervisor. The month end report will identify the following:

   - total patients who applied for the Free Bed Fund.
   - determination of the Free Bed Fund application process
   - total dollar amount applied toward each of the Free Bed Funds
   - total balance remaining in each Free Bed Fund

A quarterly update of the status of all Free Bed Funds will be provided to the Vice President, Finance.

Uninsured Patient Procedure

1. The patient is registered by the Admitting Registrar who will identify the patient as having no medical insurance (self pay).

2. The patient will be given a Financial Assistance Pamphlet that will identify all Griffin Hospital Free Care assistance programs. The pamphlet also includes hospital contacts for patients seeking State welfare, Saga (City welfare), or other State programs.

3. Patients who register as having no medical insurance with account balances over $3,000 will be referred to the hospital Eligibility Worker. The patient will be seen or contacted by phone within 24 hours of admission. If the Eligibility Worker is unable to ensure this requirement, a Financial Advisor will take the necessary steps to fulfill this requirement. All accounts under $3,000 will be referred to the hospital Financial Advisors.

4. The hospital Eligibility Worker will complete a financial screening for those patients seeking Title 19 eligibility and for the uninsured status.

5. The hospital Eligibility Worker will identify all patients meeting the State/Saga and Husky program criteria. For patients meeting the criteria, the application process will be completed and all paperwork forwarded to the appropriate State department for processing.

6. The patients who do not meet the criteria for the State/Saga/Husky programs will be referred to the hospital Financial Advisor.

7. The Financial Advisor will begin a review to determine if the patient meets the uninsured criteria identified in Public Act 03-266. A letter will be sent to the patient requesting the patient to verify that they do not have medical insurance as identified during their hospital registration process. The letter will also request additional patient information regarding the patient's income if necessary. The criteria the patient must meet as identified in Public Act 03-266 are as follows:

   - patient's income, based on family size, falls under 250% of the poverty income guidelines (see attached poverty income guideline scale).

- hospital has made a full determination as to the status of the State/Saga/Husky programs (if applicable)

- all Griffin Hospital Free Bed funds have been reviewed and determined non-applicable for the patient in review

8. If the patient responds to the letter sent out by the Financial Advisor, this will begin the application process for the verification of the uninsured patient status. The following information will need to be finalized with the patient in order for the uninsured determination to be made:

    - proof of patient income and family size
    - hospital has made a final determination as to the status of the State/Saga/Husky programs (if applicable)
    - verification of all Free Bed Funds being reviewed with the patient

9. Upon determination that a patient meets the outlined criteria, the patient will be classified as follows:

    - Uninsured Status; the patient's account will be taken from total gross charges and reduced to cost by applying factor supplied annually by OHCA.
    - The patient will be informed of this decision and will be sent a copy of their bill which will reflect the balance at reduction
    - The patient will be advised of the balance that is due and payable.

10. The Financial Advisor will contact the patient to accomplish the following:

    - attempt a payment arrangement with the patient on the remaining balance
    - if the patient identifies to the Financial Advisor that they cannot afford the remaining balance, an application for Free Care assistance will be completed (see Free Care Assistance below)

11. If a patient applies for Free Care Assistance, the Financial Advisor will make a decision on Free Care eligibility based on the patient's family size and income. Free care will be offered based on the Griffin Hospital Free Care assistance sliding scale (see attached sliding scale).

12. The Financial Advisor will advise the patient of the free care determination which will be applied to the patient's remaining balance.

13. The Financial Advisor will complete all appropriate logs with the decisions and amounts.

Free Care Assistance:

1. Any patient requesting financial assistance in paying their Griffin Hospital bill can apply for the Free Care Assistance Program by contacting the hospital's Financial Advisory staff.

THE GRIFFIN HOSPITAL
STANDARD OPERATING POLICIES

SUBJECT: FREE BED FUNDS/UNINSURED PROCESS/FREE CARE ASSISTANCE

2. The Financial Advisor will be contacted by the patient to complete the Free Care application process.

3. The Financial Advisor will obtain the following information from the patient in order to complete the Free Care Application. The information required from the patient to complete the free care application is as follows:

   - Patient W-2 form (tax statement from previous and current year.
   - Three consecutive paystubs from patient's current employment.
   - Dependent information (family size)
   - Any or all bank and checking account statements.

4. The Financial Advisor will refer to the Griffin Hospital sliding scale. This is based on the Federal government Poverty Income Guidelines (see attached sliding scale). The Financial Advisor will make a determination of free care eligibility status.

5. If the patient qualifies for Free Care assistance, the applicable discount percentage will be applied to the patient's account balance.

6. If a patient balance remains, the Financial Advisor will complete one of the following with the patient:

   - require payment in full;
   - set up a monthly payment arrangement

7. If the patient does not maintain the agreed upon payment schedule, the account will be forwarded to an outside collection agency at the full remaining balance.

8. If a patient does not qualify for Free Care assistance, the Financial Advisor will attempt to:

   - attempt to obtain payment in full;
   - set up a monthly payment arrangement;
   - offer a 20% discount on balance to be paid within 10 business days of agreement

9. If a patient does not maintain the agreed upon payment schedule, the account will be forwarded to an outside collection agency at the full remaining balance.

10. If it is later determined by the Griffin Hospital or a collection agency acting on behalf of Griffin Hospital that the patient's financial conditions have changed and the patient was unable to pay the outstanding account balances, an override may be applied by the Business Services Collection Supervisor or Director of Business Services. All overrides will also have to be signed off by the Business Services Collection Supervisor and Business Services Director.

11. The Collection Supervisor will maintain all monthly spreadsheets that will identify all Free Bed funds, Uninsured, and Free Care Assistance allocated on a monthly basis.

12-028-AR

Griffin Hospital Sliding Scale
For the Uninsured Patient - February 1, 2012

Size of Family	of 250% HHS Poverty Income Guidelines: 100% FreeCare		of 280% HHS Poverty Income Guidelines: 85% FreeCare 15% Patient Share		of 310% HH s Poverty Income Guidelines: 75% FreeCare 25% Patient Share		of 340% HHS Poverty Income Guidelines: 50% FreeCare 50% Patient Share		of 370% HHS Poverty Income Guidelines: 35% FreeCare 65% Patient Share		of 400% HHS Poverty Income Guidelines: 30% FreeCare 70% Patient Share	
	Greater Than	Up to	Greater Than	Up to	Greater Than	Up to	Greater Than	Up to	Greater Than	Up to	Greater Than	Up to
1	0	27,925	27,926	31,276	31,277	34,627	34,628	37,978	37,979	41,329	41,330	44,680
2	0	37,825	37,826	42,364	42,365	46,903	46,904	51,442	51,443	55,981	55,982	60,520
3	0	47,725	47,726	55,720	55,721	59,179	59,180	64,906	64,907	70,633	70,634	76,360
4	0	57,625	57,626	64,540	64,541	71,455	71,456	78,370	78,371	85,285	85,286	92,200
5	0	67,525	67,526	75,628	75,629	83,731	83,732	91,834	91,835	99,937	99,938	108,040
6	0	77,425	77,426	86,716	86,717	96,007	96,008	105,298	105,299	114,589	114,590	123,880
7	0	87,325	87,326	97,804	97,805	108,283	108,284	118,762	118,763	129,241	129,242	139,720
8	0	97,225	97,226	108,892	108893	120,559	120,560	132,226	132,227	143,893	143,894	155,560

1. Source: Federal Register, Vol.76, No.13, January 26, 2012. PP 3637-3638

2. For family size with more than eight (8) members add $3960 for each additional member.

3.This sliding scale is based on the 2012 HHS Poverty Guidelines for the 48 continous states and District of Columbia

Effective 2/1/2012

Griffin Hospital Sliding Scale
For the Insured Patient having a Copay/Deductible/Coinsurance balance February 1, 2012

Size of Family	of 250% HHS Poverty Income Guidelines: 100% FreeCare Greater Than	Up to	of 280% HHS Poverty Income Guidelines: 85% FreeCare 15% Patient Share Greater Than	Up to	of 310% HH s Poverty Income Guidelines: 75% FreeCare 25% Patient Share Greater Than	Up to	of 340% HHS Poverty Income Guidelines: 50% FreeCare 50% Patient Share Greater Than	Up to	of 370% HHS Poverty Income Guidelines: 35% FreeCare 65% Patient Share Greater Than	Up to	of 400% HHS Poverty Income Guidelines: 30% FreeCare 70% Patient Share Greater Than	Up to
1	0-27,925		27,926	31,276	31,277	34,627	34,628	37,978	37,979	41,329	41,330	44,680
2	0-37,825		37,826	42,364	42,365	46,903	46,904	51,442	51,443	55,981	55,982	60,520
3	0-47,725		47,726	55,720	55,721	59,179	59,180	64,906	64,907	70,633	70,634	76,360
4	0-57,625		57,626	64,540	64,541	71,455	71,456	78,370	78,371	85,285	85,286	92,200
5	0-67,525		67,526	75,628	75,629	83,731	83,732	91,834	91,835	99,937	99,938	108,040
6	0-77,425		77,426	86,716	86,717	96,007	96,008	105,298	105,299	114,589	114,590	123,880
7	0-87,325		87,326	97,804	97,805	108,283	108,284	118,762	118,763	129,241	129,242	139,720
8	0-97,225		97,226	108,892	108893	120,559	120,560	132,226	132,227	143,893	143,894	155,560

1. Source: Federal Register, Vol.76, No.13, January 26, 2012. PP 3637-3638

2. For family size with more than eight (8) members add $3960 for each additional member.

3.This sliding scale is based on the 2012 HHS Poverty Guidelines for the 48 continous states and District of Columbia

Effective 2/1/2012

Griffin Health Services Corporation

Griffin Hospital

Financial Assistance Programs

Griffin Hospital has financial assistance resources available to those who qualify. Call us to speak to a financial advisor who can help you understand your hospital bill and provide assistance with the following:

- **Free Bed funds**
- **Free Care assistance fund**
- **Payment plan program**
- **Settlement agreements**

The following free bed/free care funds are available to Griffin Hospital patients. Patients can reapply on an annual basis.

The Eno Fund - Applicant must be a worthy protestant woman, 60 years of age or older, and be a resident of Ansonia, Derby or Seymour.

Pine Trust - Available to indigent patients of Griffin Hospital, who reside in the city of Ansonia.

DN Clark - Available to Shelton residents.

In addition to the grants listed above, you may qualify for free care, available to all Griffin Hospital patients proving hardship.

To find out if you qualify, call

(203) 732-7375

or toll free 1-800-354-3094
(ask for business services)
Monday - Friday
8:00 AM - 5:00 PM

To speak to an eligibility specialist who can help you obtain medical coverage, call (203) 732-1193.

130 Division St. • Derby, CT 06418

12-028-MR

Programas de Ayuda Financiera

Griffin Hospital tiene recursos de ayuda financiera disponibles para aquellos que califiquen. Llámenos para hablar con un asesor financiero quien lo podrá ayudar a comprender mejor las facturas del hospital y proporcionarle asistencia con lo siguiente:

- **Fondos para camas gratuitas**
- **Fondos para ayuda de atención gratuita**
- **Programa de planes de pago**
- **Convenios de liquidación**

Los siguientes fondos para cama/atención gratuita se encuentran disponibles para los pacientes de Griffin Hospital. Los pacientes pueden volver a postular en forma anual.

Eno Fund: La postulante debe ser una mujer protestante merecedora, de 60 años o más y residente de Ansonia, Derby o Seymour.

Pine Trust: disponible para pacientes indigentes de Griffin Hospital que residan en la ciudad de Ansonia.

DN Clark: disponible para personas que residan en Shelton.

Además de los subsidios mencionados anteriormente, puede calificar para atención gratuita disponible para todos los pacientes de Griffin Hospital que demuestren dificultades económicas.

Para saber si califica, llame al

(203) 732-7375

o llame gratis al 1-800-354-3094
(pida hablar con "business services")

Lunes a viernes, de
08:00 a.m. a 5:00 p.m.

Para hablar con un especialista de elegibilidad que lo pueda ayudar a obtener cobertura médica, llame al (203) 732-1193.

130 Division St. • Derby, CT 06418

12-028-AR

G...n Health Services Corporation

Griffin Hospital

The Griffin Hospital Financial Advisor has informed me of the availability of Free Care/Grants appropriated to the Hospital.

The Financial Advisor has suggested that a State Eligibility Application be Completed. And if denied by the State for assistance a Proof of Income Application is required for consideration of the following Grants and Free Care.

Grants available:

- The Eno Fund – an applicant must be a worthy protestant women over 60 years old. And reside in the towns of Ansonia, Derby or Seymour.
- Pine Trust – Available to indigent patients of Griffin Hospital, who reside in the city of Ansonia.
- DN Clark Fund – Available to Shelton Residents proving financial hardship.

In addition to the Grants listed above I may qualify for assistance from the FREECARE FUND. This fund is available to ALL Griffin Hospital Patients proving financial hardship, with completion of a Proof of Income application.

SIGNATURE: _____ DATE: _____

Completed by financial advisor:

Account # _____

Patient Referred to Eligibility Specialist: Yes_____ No_____

Free Care application given to patient: Yes_____ No_____

Patient Qualify for any Grants: Yes_____ No_____

a Planetree affiliate

130 Division Street ■ Derby, CT 06418 ■ (203) 735-7421
A teaching affiliate of the Yale University School of Medicine
http://www.griffinhealth.org

12-028-AR

THE GRIFFIN HOSPITAL
BUSINESS OFFICE
STANDARD OPERATING POLICIES

SUBJECT: MEDICARE BAD DEBT PROCESS/LOG

EFFECTIVE DATE: 1/1/2009 SUPERCEDES: 10/2006

RESPONSIBLE DEPT: Business Office APPROVED BY:

Administrator

POLICY:

It is the responsibility of the Medicare Billing Supervisor to complete the Medicare Bad Debt Log. This log is to be completed monthly following the procedure listed below.

PROCEDURE:

Medicare Bad Debt Returns

The Credit Supervisor will identify Medicare bad debt write offs by submitting a report of returned Medicare accounts where collection efforts have been exhausted. The Credit Supervisor will print the #13 and #3 screen from the Meditech system in the BAR Module for each account written off as uncollectible. All printouts should be reviewed by the Credit Supervisor to assure appropriateness as an uncollected Medicare Bad Debt. All Medicare remittances will be pulled and copied by the Medicare Billing Staff and returned with the AR printouts to the Medicare Billing Supervisor.

Medicare/State Crossovers

For State crossovers to Medicare, the State checks will be worked by the Medicare billing staff. The Medicare staff will process the adjustments for any account that has a reason code on the State remit as (Medicare payment is equal to or exceeds Medicaid allowed charge). The dollar amount will be adjusted off to (AMEDA CTSW) and the accounts will be documented. The Medicare staff will then print the Medicare remit showing the Ded/Coins due. The Medicare staff will write the patient's State ID# on the front of the Medicare remit and give this information to the Medicare Billing Supervisor along with a copy of the State remit and copy of the write off sheets.

The Medicare Billing Supervisor will enter both the Regular Medicare Bad Debt Returns and the State (Crossover) after Medicare onto the Medicare Bad Debt Log on an Excel spreadsheet. The Medicare Supervisor will sort the Bad Debt log for duplicate payments and remove them before submitting the log to the Finance Department for the year end cost report. The Medicare Supervisor will also review each entry on the Bad Debt log to ensure that the accounts have been properly billed to the State and that no additional payments have been posted to the account after the write off has been done.

12-028-AR

THE GRIFFIN HOSPITAL
BUSINESS OFFICE
STANDARD OPERATING POLICIES

SUBJECT: MEDICARE BAD DEBT PROCESS/LOG

All completed logs, including required backup, are filed in the Medicare Billing Supervisor's office. A copy of submission goes to the Finance Department at the fiscal year end for cost reporting purposes.

Other Facts:

- Only accounts with verified backup are to be logged.
- Each month's log is to be completed by the end of the month for the previous month's activity
- Leave the last line of each page empty for page totals.
- Complete separate logs for IP, OP and CTSW after Medicare (Crossover).
- Only log deductible and/or Co-insurance amounts. Do not log Part B charges.
- A copy of the Medicare guidelines of the criteria for allowable bad debt is attached

SUBSEQUENT PAYMENTS:

Any payments received after the account has been deemed uncollectible will be reported on the Medicare bad debt log field #11 (see attached). All payments logged during the fiscal year will be reported to the Finance Department for cost reporting purposes.

MEDICARE RECOVERIES

The Credit Supervisor will keep a monthly log of payments made to the collection agency after the account has been returned as uncollectible. The Credit Supervisor will forward the log to the Medicare Supervisor who will update the Medicare Bad Debt log to reflect such payments. This will be done on a monthly basis. If a payment is received on an account for the previous fiscal year, the Medicare Supervisor will inform the Finance Department. The amount will be identified as a recovery and netted against the current fiscal year's cost report by the Finance Department.

HOW TO COMPLETE THE LOG

1.	(Field #1)	Patient Name - as it appears on the remittance.
2.	(Field #2)	HIC No. - the patient's Medicare number
3.	(Field #3)	Date of Service - date of admission from the A/R inquiry screen and the date of discharge from the A/R inquiry screen.
4.	(Field #4)	Leave blank
5.	(Field #5)	Date first bill sent to beneficiary - the date the first bill went to the beneficiary from the A/R inquiry screen (13 & 3 screens).
6.	(Field #6)	Write-off date - date the account came back from the collection agency as uncollectible.

12-022-AR

THE GRIFFIN HOSPITAL
BUSINESS OFFICE
STANDARD OPERATING POLICIES

SUBJECT: MEDICARE BAD DEBT PROCESS/LOG

7. (Field #7) Remittance advise date - the date of the payment remittance

8. (Field #8) Deductible - Part A deductible amount from remittance

9. (Field #9) Co-Insurance - Part A co-insurance amount from the remittance

10. (Field #10) Total - total bad debt amount claimed

11. (Field #11) Payments received after return date

Reviewed 10/2006; 1/2009: Business Services

12-02f-AA

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER _____ PREPARED BY: _____

NUMBER _____ DATE PREPARED: _____

FYE _____ INPATIENT _____ OUTPATIENT _____

(1) Patient Name	(2) HIC No.	(3) Dates of Service		(4) Indigency & Welfare Recip (__ if appl.)		(5) Date First Bill Sent to Beneficiary	(6) Write-Off Date	(7) Remittance Advice Dates	(8) Deductible	(9) Co-Insurance	(10) Total	(11) Payment Rec'd after Return date
		From:	To:	Yes:	Medicaid #							

12-02-R

COPYRIGHT 2000, CCH Incorporated

42 CFR §413.80 Bad debts, charity, and courtesy allowances.

(a) *Principle.* Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, except for anesthetists' services described under paragraph (h) of this section, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

(b) *Definitions.*—(1) *Bad debts.* Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.

(2) *Charity allowances.* Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

(3) *Courtesy allowances.* Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and other as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(c) *Normal accounting treatment: reduction in revenue.* Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

(d) *Requirements for Medicare.* Under Medicare, costs of covered services furnished beneficiaries are not be to borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the health insurance program. Uncollected revenue related to services rendered to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts can result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts which remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not allowable costs.

(e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

(2) The provider must be able to establish that reasonable collection efforts were made.

(3) The debt was actually uncollectible when claimed as worthless.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

(f) *Charging of bad debts and bad debt recoveries.* The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

(g) *Charity allowances.* Charity allowances have no relationship to beneficiaries of the Medicare program and are not allowable costs. These charity allowances include the costs of uncompensated services furnished under a Hill-Burton obligation. (Note: In accordance with Sec. 106(b) of Pub. L. 97-248 (enacted September 3, 1982), this sentence is effective with respect to any costs incurred under Medicare, except that it does not apply to costs which have been allowed prior to September 3, 1982, pursuant to a final court order affirmed by a United States Court of Appeals.) The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

(h) *Limitations on bad debts.* In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs (as defined in paragraph (e) of this section) is reduced—

(1) For cost reporting periods beginning during fiscal year 1998, by 25 percent;

10-038A

12-026A

COPYRIGHT 2009, CCH Incorporated

(2) For cost reporting periods beginning during fiscal year 1999, by 40 percent; and

For cost reporting periods beginning during a subsequent fiscal year, by 45 percent.

(i) *Exception.* Bad debts arising from services for anesthetists paid under a fee schedule are not reimbursable under the program.

.01 Source:

As adopted, 31 FR 14808 (Nov. 22, 1966), and amended at 32 FR 5258 (Mar. 29, 1967), and corrected at 32 FR 7126 (May 11, 1967); recodified as 42 CFR 405.420 (formerly 20 CFR 405.420) at 42 FR 52826 (Sept. 30, 1977, effective Oct 1, 1977), and amended at 47 FR 43656 (Oct. 1, 1982, effective with respect to all costs incurred under Medicare, both before and after enactment of P. L. 97-248, except those specific costs allowed under court order in *Presbyterian Hospital of Dallas* v. *Harris*), and redesignated at 51 FR 34790 (Sept. 30, 1986, effective Oct. 1, 1986), and amended at 57 FR 33878 (July 31, 1992, effective Aug. 31, 1992), and at 60 FR 63124 (Dec. 8, 1995, effective Jan. 1, 1996), and at 63 FR 40953 (July 31, 1998, effective Oct. 1, 1998).

10-028-A

12-028-A

THE GRIFFIN HOSPITAL
BUSINESS OFFICE
STANDARD OPERATING POLICIES

SUBJECT: REMITTANCE REVIEW – CO-PAY FOLLOW UP PROCESS/BAD DEBT

EFFECTIVE DATE: 8/2009 SUPERCEDES: 10/1/2006

RESPONSIBLE DEPT: Business Services APPROVED BY: James J. Moyle Administrator

POLICY:

All patient accounts finalized and processed through the electronic and paper billing processes will be worked by the cash remittance group. If the patient account has a self pay balance, i.e., co-pay, deductible, the account will be worked by the cash analyst to assure the money is moved to the appropriate self pay category.

Accounts that are either a straight self pay or self pay balances after insurance will be referred to an outside agency. The agency will work the patient accounts for all insurance payers for a period of 120 days. If a payment or a payment arrangement is not made to the agency or the hospital within the 120 day time period, the account will be forwarded back to the hospital to the attention of the Collection Supervisor. The Collection Supervisor will forward all accounts returned to an outside collection agency.

PROCEDURE:

1. Patient account registered through admissions/registration. All copies of insurance cards are maintained and forwarded to the billing department for review. The billing representative for the assigned payor group will review copy of card and identify billing information policy number as appropriate for billing purposes to carrier.

2. The patient account will be processed for coding through the Medical Records department.

3. Upon coding completion, the account will be finalized and the bill will be produced.

4. The claims will come down and all payor groups will complete a claims edit review.

5. All edits will be completed and entered into the patient account.

6. The claims will be generated either by electronic or manual submission to the assigned payor, i.e., Medicare, Blue Cross, PHS, etc.

7. All electronic claims are downloaded by claim file and transmitted through Web MD and PCACE (Medicare).

12028-Am

THE GRIFFIN HOSPITAL
STANDARD OPERATING POLICIES

SUBJECT: REMITTANCE REVIEW – CO-PAY FOLLOW UP PROCESS/BAD DEBT

8. All fast EMC edits are completed by the assigned biller.

9. Web MD claims transmitted to Blue Cross

10. All claims that cannot be teleprocessed electronically will be verified and hard copied to the specific insurance carrier.

11. All payers will forward a remittance to the hospital. The remittance will identify those claims paid or denied on accounts and have a remaining balance, i.e., co-pays/deductibles/non-covered services.

12. At this time, all remittances, i.e., Cigna, Aetna/U.S. Health Care, Oxford, Blue Cross, Medicare A & B, State and Saga/State, and Healthnet (PHS) are processed by the cash group. The group will:

    a. Post the payment
    b. Make all necessary adjustments
    c. Identify that a balance remains, i.e., co-pay/deductible and move the money to the appropriate self pay (payor).
    d. Check for secondary insurance information
    e. Make copies of EOB's for secondary review.

15. Upon completion of the remittance review, the account will reflect a true self pay balance, i.e., balance related to deductible, co-pay, self pay (no insurance).

16. If the account reflects a self pay balance, the account will be referred to an outside agency to obtain payment or enter the account into a payment plan. If no payment or payment arrangement is made by the patient within the 120 day time frame, the account will be sent back to the hospital. All accounts forwarded back to the hospital will be sent to an outside collection agency by the hospital Collection Supervisor.

R- 028- A