SUBJECT: BILLING AND COLLECTION POLICY	EFFECTIVE: 07/01/2020
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DEPARTMENT: REVENUE CYCLE	OF: 7
AUTHOR: REVENUE CYCLE DIRECTOR	REVISED: 06/22

POLICY:

It is the policy of Coquille Valley Hospital to bill patients and applicable payers accurately and in a timely manner. During this billing and collection process, staff will provide quality customer service and all outstanding accounts will be handled in accordance with the IRS and Treasury's 501(r) final rule under the authority of the Affordable Care Act.

DEFINITIONS:

Reasonable Efforts: A certain set of actions a healthcare organization must take to determine whether an individual is eligible for financial assistance under Coquille Valley Hospital's financial assistance policy.

Amounts Generally Billed: The Amounts Generally Billed (AGB) is defined as the maximum amount a patient who qualifies under the financial assistance policy for charity or other discount will be billed.

Extraordinary Collection Actions (ECAs): As defined in Section 501(r)(6) of the Internal Revenue Code, ECAs are defined as actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's Financial Assistance Plan (FAP) that:

- Involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus.
- Place a lien on an individual property except those allowed under state law due to judgments or settlements as part of a personal injury case.
- Commence civil action against an individual or writ of body attachment.
- Garnish an individual's wages.
- Extraordinary collection actions do not include a lien asserted on the proceeds of a judgment, settlement or compromise owed to an individual as a result of personal injury for which medical services were provided. Moreover, the AGB and FAP protocol does not apply to trusts, estates, partnerships, associations, corporations, LLC's, government agencies, nonprofits or businesses that assume the individual's debt. However, with regards to actions within this policy the facility will consider any individual who has accepted or is required to accept responsibility for an individual having medical treatment rendered as equivalent to the first individual receiving a hospital bill for the care.

Collection Agency: A collection agency is defined as an outside, non-hospital agency engaging in bad-debt collection activities as opposed to an outside agency simply carrying out the hospital's normal billing function.

Financial Assistance: Healthcare services that have been or will be provided for free or at a reduced cost to individuals who meet established criteria.

Financial Assistance Policy (FAP): A separate policy that describes Coquille Valley Hospital's financial assistance program - including the criteria patients must meet in order to be eligible for assistance as well as the process by which individuals may apply for financial assistance.

Guarantor: The individual responsible for paying patient's bill. Patient statements are addressed to this person. For individuals under 18, a parent or legal guardian/trustee is the guarantor.

Health Insurance: The term used for any coverage that provides for the payment of medical services from the result of sickness or injury or wellness benefit.

Third Party Payer: An insurance carrier or plan. The patient is considered the first party, the provider of service is considered the second party, and the insurance company paying for the service rendered is considered the third party.

PROCEDURE:

Billing Practices

A. Insurance Billing

- Contracted Insurance Plans - Coquille Valley Hospital contracts with a number of insurance plans. In those cases, the Hospital will seek payment from the insurance plan for all covered services. Routine co-payments will be requested at the time of service and deductibles may be requested at the time of service for non-emergency services.

If a particular service is determined by the insurer to be non-covered or otherwise rejected for payment, then payment for that service will be sought directly from the patient in accordance with the relevant insurance contract. Whenever possible, the Hospital will assist the patient in appealing denials or other adverse judgments with their insurance plan recognizing that the insurance plan often requires these appeals to be made by the patient.

- Non-Contracted Insurance Plans - The Hospital will extend the courtesy of billing a patient's insurance company in those cases where the Hospital does not have a contract with an insurer. While the Hospital will bill the patient's insurance plan, ultimate financial responsibility rests with the patient or guarantor.

- For all insured patients, Coquille Valley Hospital will bill applicable third-party payers (as based on information provided by or verified by the patient) in a timely manner.
- If a claim is denied (or not processed) by a payer due to an error on our behalf, Coquille Valley Hospital will not bill the patient for any amount in excess of what the patient would have owed had the payer paid the claim.
- If a claim is denied (or is not processed) by a payer due to factors outside of our organization's control, staff will follow-up with the payer and patient as appropriate to facilitate resolution of the claim. If resolution does not occur after prudent follow-up efforts, Coquille Valley Hospital may bill the patient or take actions consistent with current regulations and industry standards.

B. Patient Billing

Coquille Valley Hospital will prepare and mail statements to patients on a regular basis to advise them of balances owed to the Hospital. In general, patients should receive three (3) or more statements or letters over the course of a billing cycle that is expected to last 120 days provided other actions do not occur which indicate that additional billing is inadvisable. A record of all account actions and communications, including statements, is reflected in the billing system. Staff are required to document all contacts with the patient (or guarantor) in the applicable billing system.

Suspension of Billing - In certain situations, continued billing and collection activity may be inappropriate and may be suspended or discontinued. Such situations include, but are not limited to: Incorrect address, bankruptcy cases, deceased patient, patient complaint or a customer service issue.

Notification of Availability for Financial Assistance - Patient statements will include any notices required by regulations to inform patients of the availability and means to apply for financial assistance. The language and content of these notices will conform to IRS 501(r) regulations.

Incorrect Address Returns - The Hospital will make reasonable efforts to track and respond to all patient statements returned by the USPS that are not deliverable. Where possible, accounts will be identified as "Mail Return" in the billing system, and address information will be verified and corrected (if applicable) using Search America in the billing system. Generally, once an account has been flagged as mail return, no further statements or letters should be processed unless a new address has been identified.

Small Balance Adjustment - Recognizing the cost of statement processing and collection activities, the Hospital may suppress statements on accounts below its "small dollar billing" threshold.

- All uninsured patients will be billed directly and timely, and they will receive a statement as part of the organization's normal billing process. The billing statement will include information on how to apply for financial assistance.

- For insured patients, after claims have been processed by the third-party payer(s), Coquille Valley Hospital will bill patients in a timely fashion for their respective liability amounts as determined by their insurance benefits.

- All billing statements include a copy of the Plain Language Summary of Hospital Financial Assistance and how to apply.

- All patients may request an itemized statement for their account(s) at any time free of charge.

- If a patient disputes his or her account and requests documentation regarding the bill, staff members will provide the requested information in writing within 14 days (if possible) and will hold the account for 30 days before referring the account for collections.

- Coquille Valley Hospital provides payment plan arrangements for patients who indicate they may have difficulty paying their balance in a single installment.

    - Coquille Valley Hospital is not required to accept patient-initiated payment arrangements and may refer accounts to a collection agency, as outlined below, if the patient is unwilling to make acceptable payment arrangements or has defaulted on an established payment plan.

- Payment in full is due upon receipt of the first patient billing statement unless prior payment arrangements have been approved by Coquille Valley Hospital.

Bad Debt Placement

An account will be eligible for transfer to bad debt status if the outstanding balance has been determined to be the patient's responsibility, the account has aged 121 days from the initial billing statement and no payments have been made, and/or the guarantor has defaulted on an established payment plan.

- Patient balances may be referred to a third party for collection at the discretion of Coquille Valley Hospital.

- If an account remains unpaid more than 121 days after the initial statement, and reasonable collection attempts have failed, the debt may be deemed bad debt.

Reasonable collection efforts include, but are not limited to the following:

  - The issuance of a statement for medical services on or shortly after discharge or delivery of services of the patient.
  - Subsequent statements and/or telephone calls with the patient or guarantor demonstrating genuine collection efforts.

- If a patient is covered under the hospital's financial assistance program with an extended payment plan and the payments are not met, the hospital must take the following actions before an account can be assigned to a collection agency:
  - Attempt to contact the patient by phone.
  - Give notice in writing that the plan may become inoperative.
  - Inform the patient of the opportunity to renegotiate the payment plan and attempt to do so if requested by the patient.
  - The notice and phone call may be made to the last known address and phone number of the patient.
- After the final statement for a delinquent account is issued, the account is reviewed a final time before the assignment to a collection agency to ensure that a financial assistance application is not pending.
- Coquille Valley Hospital contracts with external collection agencies, but retains full ownership of the accounts receivables and has final say in any account resolution.
- Any agency seeking to collect patient balances on behalf of Coquille Valley Hospital will be required to conform to this Billing and Collection Policy. Any substantive patient complaints will be reported to CVH for review and tracking.
- Agencies will report any collections, or other account actions, including the decision to cease collection efforts, on a daily basis. Agencies will cease collection efforts on any account placed with them for one year that has had no action, payment or any current potential for payment. Uncollectable accounts meeting these criteria will be returned to CVH on a quarterly basis.
- The patient will be informed in writing no less than 30 days before any ECAs are initiated. The 30-day notice will include a copy of the Plain Language Summary of Hospital Financial Assistance Policy. A phone call attempt to contact the guarantor will be performed by the agency as a part of the 30-day notification of the ECA. The Agency is responsible for making this notification before any and all ECAs are initiated.
- Coquille Valley Hospital will refrain from initiating any ECAs for at least 240 days from the date of the first post-discharge billing statement for the patient's care.

- If a financial assistance application is made when an account is already assigned to a collection agency, the agency will put the account on hold during the duration of the application process.

- If the hospital is made aware of any verified Medicaid or other insurance coverage, the account will be recalled from the agency for Medicaid covered patients. For any other identified insurance coverage, the account will be placed on hold to allow for billing, provided the service is within timely billing guidelines per the patient's insurance policy.

- Any legal actions against a patient will be limited to liens, lawsuits, and/or wage garnishment. Any legal actions must be approved by the Chief Financial Officer or Revenue Cycle Director, and the proper 30-day notice in advance of such activities must be completed by the collection agency.

Patient Rights and Responsibilities

It is the patient's obligation to:

- Provide complete and timely insurance and demographic information, and to inform the Hospital, and the State if the patient is on a State Program, of any changes in their status including, but not limited to, changes in income or insurance status.

- Apply for and maintain coverage through any government sponsored programs for which they may qualify, including submission of all required documentation within the required time-frames. All patients should obtain and maintain insurance coverage if affordable coverage is available to them.

- Notify the Hospital of any potential Motor Vehicle Accident coverage, Third Party Liability coverage or Workers compensation coverage.

- Make reasonable efforts to understand the limits of their insurance coverage including network limitations, service coverage limitations and financial responsibilities due to limited coverage, co-payments, co-insurance and deductibles.

- Conform to insurance referral, pre-authorization and other medical management policies.

- Conform to other insurance requirements, including completion of coordination of benefit forms, updating membership information, updating insurance information, updating physician information and other payer requirements.

- Pay co-pays, deductibles and co-insurance in a timely manner.

- Provide timely updates of demographic and insurance data.

The Hospital will not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, gender identity, sexual orientation, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits and payment plans.

Other Applicable Policies:

CVH Financial Assistance Policy
CVH Payment Plan Policy
Coquille Valley Hospital Clinics Payment Policy

A copy of this policy may be requested by mail, free of charge, or by calling Patient Financial Services at (541) 824-1234, or in person at: 940 East 5th Street, Coquille, OR 97423.