



Self Pay Follow-Up Policy

POLICY

Overlake Hospital Medical Center (OHMC) recognizes the importance of collecting the self-pay portion of patient accounts as being key to the fiscal health and the revenue cycle of the hospital. In the case of a private pay patient, 100% of the patient account is the patient responsibility. OHMC also recognizes that financial difficulties may accompany the receipt of health care services and is sensitive to this fact in its collection policies and procedures as well as in its Financial Assistance Programs.

PROCEDURE

After all insurance payers covering a patient have paid or denied a claim, the patient responsibility, as identified by the remittance advice of the payer(s) is moved to the Patient/Guarantor Responsibility (PR) line in billing system. In the case of a private pay patient, where there is no insurance payer, the full balance of the claim moves to the PR line of the system immediately upon the Abstracting/Coding Departments finalization of the account.

Once the patient balance has moved to the Patient Responsibility line, and as long as the guarantor balance exceeds \$14.99 (the small balance write off threshold), the system generates the appropriate Statement Message on the outgoing billing statement and contains the account balance for which they are responsible. If the patient/guarantor has not made full payment or made other arrangements (as outlined under the Financial Assistance Programs section below), within thirty (30) days of the system generating Statement Message #1, the system generates Statement Message #2.

At this point, the assigned Patient Account Representatives in the Patient Financial Services Department become involved in the collection process. The Patient Account Representatives prioritize their workload by account balance and account age. The Patient Account Representatives review system work queues that provide them a list of all of the patients who have received a Statement Message #2. Utilizing appropriate HIPAA compliant procedures, they attempt to call the guarantor to remind them that they have a balance due and to determine if the patient is in need of one of the Financial Assistance Programs.

If the guarantor has not made full payment or other arrangements with OHMC within thirty (30) days from the system generating Statement Message #2, the system generates Statement Message #3. This Statement Message warns the guarantor that continued lack of full payment or action to establish other arrangements with OHMC may result in referral to an outside collections agency. The Patient Account Representatives again attempt to reach the guarantor via telephone in an attempt to make a final effort to obtain payment or establish a Financial Assistance Program. The Patient Account Representatives clearly inform the guarantor that they will be sent to an outside collections agency if they remain non-responsive. If the guarantor has failed to make full payment or take other action thirty (30) days after the system generates Statement Message #3, the system generates Statement Message #4, which informs the guarantor they must pay within thirty (30) days or they will be sent to an outside collections agency. Failure on the guarantor's part to take action at this point results in the guarantor being considered as Bad Debt and the account is referred to an outside collections agency.

Financial Assistance Programs

OHMC offers several programs to assist guarantors with managing the financial burden of paying for health care services. The Financial Counselors and Self Pay Collectors are responsible to utilize the programs as applicable to the guarantor to assist in the collection of the full guarantor responsibility balance. In the case of charity/uncompensated care between 65% to 100% of the outstanding balances may be waived. OHMCs Charity Care program is outlined under a separate policy and procedure. The Programs are as follows:

Prompt Pay Discount Program

This program is available only for medically necessary services where there is no insurance coverage under their benefit plan (patients who are eligible under a medical insurance program, but there is no insurance coverage for the service because they have maximized their benefit limits). The guarantor is granted a 30% discount from the total account charges by paying OHMC their full balance within 30 days of the date of their first billing statement. Deposits paid prior to services being rendered will be considered as part of the overall payment toward discounted balances. Elective services utilizing the PPD program rates must be paid prior to services and are not eligible for any additional payment reductions..

Extended Payment Plan Programs

This program is available to provide financial assistance with the guarantor responsibility portion of a claim after insurance has made payment or where no insurance benefits exist. The Patient Account Representatives can work with a guarantor to establish an extended payment plan. OHMC the following payment plan structure:

Amount Owed	Maximum Months to Pay
\$0 to \$300	4 (minimum \$50/mo)
\$301 to \$750	6
\$751 to \$1,500	12
\$1,501 to \$2,500	18
>\$2,500	25

Payment arrangements should not exceed 25 months in duration. If the guarantor is unable to pay under these terms, a temporary payment arrangement may be executed with reassessment after a designated period of time. The temporary arrangements must fall within the minimums established in this policy, with the first payment due upon establishment of the payment plan.

The Patient Account Representatives are equipped with correspondence and written agreements to send to the guarantors who choose to utilize an extended payment plan. If a guarantor misses a payment, the Patient Account Representatives contacts the guarantor to determine the reason and to prompt payment. Continued delay in payment will result in referral of the account to collections as bad debt.

Charity Care/Financial Assistance

This program is available to provide financial assistance with the patient responsibility portion of a claim after insurance has made payment or where no insurance benefits exist. The

patient/guarantor may request, or a Patient Account Representatives may offer to send the patient/guarantor a charity care application. Upon the guarantors return of the complete application (including supporting documentation), a Patient Account Representative reviews the application for completeness and calculates the household income as outlined in the Charity Care/Financial Assistance Policy. The Patient Account Representative who receives the charity care application from the patient/guarantor is responsible to place the guarantors account on hold in billing system, so the guarantor does not continue to receive Statement Messages during the time OHMC is calculating the guarantor's eligibility for charity care. In addition, the Patient Account Representative who reviews the application must inform the guarantor in writing of their approval (including the write off amount) or denial for charity care. Patient Financial Services management are involved in the review and calculation of the charity care adjustments and the charity care percentage is tracked with OHMCs Controller. Guarantors who do not qualify for Charity Care discounts, have the right to appeal the initial decision in writing to the Director, Revenue Cycle.

Returned Mail and Incorrect Telephone Numbers

If Statement Messages are returned to OHMC from the mail service, attempts are made to obtain a corrected address. The first step is to check the guarantors account history with OHMC to determine if the guarantor has other accounts in the system with a correct address. If this information is not available, all telephone numbers provided by the guarantor are called to request a corrected billing address. Once corrected information is obtained, the Patient Account Representatives or Patient Access Service Coordinator updates the information in the billing on all open accounts attributed to that guarantor. If corrected information is not available via any of these means, the guarantor account is considered bad debt and assigned to an outside agency for handling.

Referring an Account to Collections and Monitoring the Performance of the Collections Agencies

Accounts that have received all 4 billing statements and have no payment activity in the previous 30 days will automatically move to collection agencies for follow up activity. Accounts fall into the collection agency specific work queues as they qualify based on system settings. The Director, Revenue Cycle process the accounts to create the weekly assignment files. Collection agency liquidation rates are benchmarked in the monthly Key Performance Indicators report.