

Policy 12.2.0: FISCAL AFFAIRS--GENERAL

POLICY 12.2.1.a: PATIENT FINANCIAL POLICY

Harney District Hospital does not exclude any person from admission or treatment due to inability to pay, or who is unable to obtain assistance to pay for needed services. Patients with the ability to pay, in whole or in part, will be expected to pay for services rendered to the fullest extent possible and/or allowed by law through third-party insurers or through private assets. Patients may be excluded from non-emergent services if they are able to pay for services, but refuse to do so.

A. PAYMENT RESPONSIBILITY

The Hospital recognizes that the patient, or legal guardian in the case of a minor or legal incompetent, is singularly responsible for full payment of all charges incurred for his/her services.

The assignment of insurance benefits to the hospital does not eliminate the patient's or other responsible party's liability for any or all charges for services rendered (except as may be agreed to in applicable insurance contracts), nor does the acceptance by the hospital of any such assignment constitute an acknowledgement either expressed or implied that amounts so covered relieve the responsible party's responsibility of primary liability.

This hospital reserves the right to exercise all legal collection methods, including the imposition of late fees, interest, lawsuits, and the assignment to outside collection agencies, to effect payment of delinquent patient accounts.

The hospital will not become involved as a party to disputes arising between patients and insurance carriers over benefits paid or denied, nor will it be responsible to either party in matters involving refunds of over-payments made to either party.

Amounts due and payable from patients shall be regarded as delinquent if not paid, or satisfactory payment arrangements made, within 30 days of the initial statement date. Satisfactory arrangements must be made with the Patient Accounts Representative, and typically will involve monthly payments of 5% or more of the original balance paid every 30 days, and no less than \$25 dollars per month. Exceptions to these arrangements will require the completion of a financial statement by the patient, and approval by the Business Office Manager or the Chief Financial Officer.

B. ADMISSION REQUIREMENTS

The hospital will pre-register non-emergent patients and verify methods of payment prior to rendering service. It is the responsibility of the patient or responsible party to provide the hospital with all information necessary to establish ability to pay for the services, and to make payment arrangements if necessary.

Where third party indemnity applies, the patient or responsible party will execute an assignment of insurance benefits in favor of the hospital.

The hospital reserves the right to require any patient having no insurance or other valid third party indemnity, or who having such an insurance or indemnity declines assignment of those benefits to the hospital, or who has previously been assigned to collection for non-payment of hospital services, a cash deposit as a condition of admission of such amount that will cover the estimated costs of the services anticipated to be rendered.

In the absence of an acceptable method of payment, or a refusal to provide a financial statement or otherwise agree to satisfactory payment arrangements, a non-emergent patient may be denied services. The attending health care provider must be notified of this decision, and the non-emergent status must be confirmed by the provider or by medical screening exam at the hospital.

Patients determined to be emergent will be treated and stabilized, regardless of their ability to pay. Patients who have been determined to be indigent by the Patient Accounts Representative, and approved by the Business Office Manager or CFO, will be provided service at the hospital. The value of these indigent services provided will be recorded in a separate journal, and the amount reported regularly to the Board.

C. DISCHARGE REQUIREMENTS

Patients with verified third party insurance benefits will be allowed a 60 day period after date of discharge or service for the hospital to receive those assigned benefits. Extension of this time frame may be granted for delays caused solely by the hospital. At the end of the 60 days, the patient will be invoiced for the balance due, and the patient is responsible for resolving payment or contractual disputes with their insurance company. The hospital's sole responsibility then becomes to provide documents and medical records requested in writing by either party. Medicare, Medicaid, Oregon Health Plan, Clear Choice, COHIS, Worker Compensation, Indian Health Service, and Blue Cross will not be billed to the guarantor.

Self-pay patient accounts and balances of patient accounts in excess of amounts deposited upon admission are due and payable in full by the patient on the day of discharge unless satisfactory payment arrangements have been made in writing. Payment by cash, personal check and credit/debit card are encouraged.

D. EXCEPTIONS

The hospital Administrator or the CFO may approve exceptions to this Patient Financial Policy when it is in the best interest of the hospital. Such exceptions will be documented in writing in the specific patient account.

POLICY 12.2.1.b: EMPLOYEE USE OF DISTRICT MEDICAL SERVICES (approved 7/03)

A. POLICY STATEMENT

A healthy workforce allows the District to function at its fullest productive capacity. Because an employee's failure to seek medical help could negatively impact job performance, the District encourages its employees to seek medical services whenever necessary. The rural nature of Harney County necessitates that some employees use medical services provided by the District. Although the District is pleased to offer these medical services, the responsibility for payment lies with the employee.

B. ABUSE OF MEDICAL SERVICES

Employees are obligated to not abuse medical services provided by the District. An employee's failure to pay charges associated with medical services jeopardizes the financial integrity and credibility of the District. An employee's continued failure to pay charges associated with the use of District medical services will result in discipline or discharge. The procedures for discipline and discharge are found in Policy 8.11.0 – 8.11.5 of this personnel manual.

C. WAGE DEDUCTIONS FOR EMPLOYEE USE OF MEDICAL SERVICES

Employees are expected to pay for their medical services in the same manner as any other patient; including lump sum payments, authorized time payments and forgiveness of complete or partial balances per accepted financial statement. When an employee fails to establish and/or make adequate payment provisions, the District is authorized, pursuant to Oregon law, to make deductions from an employee's wage or salary. To facilitate this all new and existing employees are required to sign an authorization allowing the District to deduct up to 10% of each pay check to be applied to any amounts past due more than 90 days.

POLICY 12.2.2: INSURANCE BILLING

The hospital will bill the primary and secondary insurance carriers of the patient. Hospital admitting and business office personnel will make every effort to request and obtain accurate and current insurance billing information from the patient, including confirming the insurance name, number, and billing address at each time of admission, copying the insurance card for the patient record, and verifying active coverage with the insurance company. This practice notwithstanding, it is solely the patient's responsibility to assure that the hospital has current and accurate insurance information to bill on the patient's behalf, that the patient will fully cooperate in alerting the hospital when insurance is refusing payment, will fully cooperate with requests from the hospital and/or insurance carrier for additional information, forms, and signatures, and finally that any dispute arising from non-payment of claims must be resolved between the patient and his/her insurance carrier.

The hospital will maintain an internal system of processing claims such that the average claim will be assembled, coded, and electronically billed within 14 days of service.

POLICY 12.2.3: CREDIT POLICY

Harney District Hospital provides emergent medical care regardless of the financial abilities of the patient. All services are rendered on a cash basis, but credit may be granted based on the financial situation of the patient, and considering their past compliance with the hospital credit and payment policies. With the assistance of the Patient Accounts Representative (PAR), satisfactory payment arrangements will be tailored to the individual capacity of the patient or guarantor. In cases where the patient does not have insurance or other means to pay the balance at the time of service, a credit application must be filled out, and credit arrangements made with the assistance of the Patient Account Representative.

Credit may be extended according to the following guidelines:

1. All accounts are to be paid in full within 30 days from the date of initial statement billing, unless satisfactory payment arrangements are agreed to with the PAR.
2. Satisfactory payment arrangements will include monthly payments of at least 5% of the original statement balance, but no less than \$25 per month in any case.
3. All payment arrangements will comply with State and Federal guidelines and disclosures, if any.
4. All payment arrangements will be documented in writing, either as an entry into the patient record, or as a promissory note signed by the patient or guarantor.
5. If the agreed to payment is not received within 10 days after the due date, late fees may be imposed and collection procedures may begin immediately. These procedures may include the imposition of interest charges and fees, legal action, notification of credit rating agencies, and assignment of the account to outside collection agencies.
6. Exceptions to this policy may be approved by the hospital Administrator or the CFO, if in the best interest of the hospital, and the decision is documented in writing in the patient record.

Any patient or guarantor who has violated the District Credit Policy will have their patient record marked as a Credit Risk. These patients will be asked to provide payment prior to receiving non-emergent services at Harney District Hospital. "Payment" may include cash, checks, credit/debit cards or satisfactory payment arrangements, based on the judgment of the PAR.

POLICY 12.2.4: ACCOUNT WRITE-OFF POLICY

Harney District Hospital will make every reasonable effort to collect payment in full (subject to applicable laws and insurance contracts), or collect partial payments, or convert accounts to monthly payments on all patient accounts. However, those accounts deemed uncollectible after a thorough collection effort, or by contractual agreement, will be written off the financial accounts, and will not be counted as a financial asset of the hospital. All write-offs and contractual adjustments must be reviewed by the CFO, on a daily basis, using the Adjustment Journal report.

A. CONTRACTUAL ADJUSTMENTS AND ALLOWANCES

The hospital agrees to waive certain percentages of charges with some insurance providers, such as Medicare, Welfare, Blue Cross and others. When posting insurance receipts from these insurance carriers, this insurance contractual adjustment will also be posted to the patient account. Any remaining balances, deductibles, and co-pays (except those forbidden by law or contract) will be billed to the secondary insurance carrier or to the patient as a self-pay balance. Contractual adjustments are written off as a deduction from patient revenue. An objective of Harney District Hospital is to minimize this adjustment, and to hold the total contractual adjustment to less than 25% of gross patient revenue.

B. BAD DEBT/ COLLECTIONS

Patients and guarantors violating the hospital Credit Policy, including failure to pay the full balance due, or to make monthly payments as agreed, will be subject to a collection effort. After a reasonable collection effort, if it is determined by the Patient Account Representative that the patient will not pay the balance due, and will not cooperate in the effort to determine if the patient is eligible for a partial or full adjustment of the balance due, then the patient account will be sent to an outside collection agency and will be written off the accounts receivable list in the hospital financials.

Bankruptcies are a special case of this policy. If a patient or guarantor is declared bankrupt by a court order, the hospital may not pursue collection efforts nor may it send the account to an outside collection agency. Upon receipt of written proof of the court order, the notice of bankruptcy will be entered into the patient record, and the balance of the account written off.

All patients with a Bad Debt write-off will be required to pay cash in full or their insurance co-pay amount for any future non-emergent services at the hospital. A notation will be made in the patient record, alerting the admitting department that the patient is a Credit Risk, and requires advance payment for non-emergent services. Removal from the Credit Risk status will require demonstration of an ongoing ability to meet a patient's financial obligations to the hospital, and must be approved by the Business Office Manager or CFO.

C. FINANCIAL NEED ADJUSTMENTS

Patients and guarantors who can demonstrate financial need may apply to have their hospital account balance reduced or eliminated. In general, the patients who qualify for the Financial Need Adjustment have financial circumstances which make unlikely the payment in full of the account balance, have almost no ability to make a payment sufficient to retire the amount in a 2-4 year period, and have circumstances which are unlikely to change in the next year or more.

To be considered for a Financial Need Adjustment, a patient must contact the hospital Patient Account Representative, and submit a complete financial application provided by the hospital. The signed application must include proof of income, copies of tax returns, and a full listing of all assets and liabilities. Falsifying information on the application will result in a reinstatement of the full, original balance due and a finding of violation of the hospital credit policy. The following guidelines will be used in determining the amount, if any, that will be adjusted from the account balance:

1. The determination is based on the patient's willingness, but inability to pay. This is contrasted with a Bad Debt account, where the patient has the means to pay or to make payment arrangements, but is unwilling to do so.
2. Other sources of payment, including the sale of assets or borrowing from friends, relatives, and institutions are considered.
3. Minimal regular payments and/or partial adjustments to the account balance are considered as the preferred option to a full adjustment.
4. Consideration is given to the events limiting the ability to pay the account, and the likelihood these events will continue in the future.
5. The ability for the Patient Accounts Representative to independently verify the information listed in the financial application.
6. All financial circumstances will be considered, including assets, sources of income, financial obligations, family size, and health status.

7. Adjustments will apply to current charges for past dates of service; future hospital services may still require another application for adjustment, depending on the determination reached on the original application.

Requests for a Financial Needs Adjustment will be reviewed and a determination issued within 30 days of receipt of a patient's application. A final determination must be reviewed and approved by the CFO. Approved requests will be reflected on the patient account immediately, and the documentation of the determination entered into the patient record. The patient will be notified of the determination by phone call or letter, even if no adjustment is approved.