POLICY MANUAL

Subject: Accounts Receivable **Effective Date:** 1/8/97

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Director of Patient Accounting

Approved By: Timothy A. Tull
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Review Dates: 03/10 JSC, 02/11 JSC, 04/12 JSC, 3/13 JSC 2/14 JSC **Revision Dates:** 3/23/10, 4/15 EMc

POLICY:

I. Accounts Receivable Philosophy:

To support the mission of Cumberland Heights, a sound financial basis is essential. Cumberland Heights is committed to the tradition of providing the highest quality care possible in a cost effective manner. Cumberland Heights recognizes that many patients are unable to pay for their treatment in its entirety at the time of discharge. For the purpose of this document, "patient" shall refer to the patient and or any other person, such as a guarantor or surety who is legally obligated to pay any portion of the patient's bill. From time to time, and at it's sole discretion, Cumberland Heights may extend credit on the estimated co-payment amounts.

Cumberland Heights believes it is important for the patient to invest in his/her own treatment. It is the goal of the accounts receivable (A/R) staff to separate those patients who do not want to pay their accounts in full from those who are unable or have limited resources to pay. Cumberland Heights will keep accounts active as long as patients are making a good faith effort to keep their payment arrangements. Patients who are identified as being unable to pay are written off as uncollectible bad debt. Those who do not want to pay are eventually referred to outside collections if they do not fulfill their obligations.

Cumberland Heights seeks to maximize the amount collected through fair and timely collection methods. These methods include the use of staff trained in the following areas: financial advisors; insurance collectors; and self pay collectors. The following sections will explain some of the procedures for which these personnel are responsible.

II. Financial Advisors

Financial advisors assist patients and family members in understanding the financial aspects of treatment. When a potential patient has limited resources the financial advisor is consulted. Using the initial course of treatment provided by the assessor as an estimate, the cost of treatment is determined. The financial advisor works with the potential patient and the assessor to arrive at a payment plan that minimizes financial risk to the facility and does not unduly burden the patient after treatment. If no such plan is feasible, then the assessor or social worker will refer the potential patient to other facilities with grant funding for indigent patients or seek a scholarship through the Patient Assistance Fund.

Financial advisors are also charged with monitoring patient's accounts for accuracy prior to discharge. Corrections to charges are submitted to data entry for correction and reoccurring problems are reported to the Director of Patient Accounting. The financial advisor meets with patients to keep them informed of changes and the costs of their course of treatment. At the time of admission, the **General Admission and Authorization** form is signed by all patients and any surety or guarantor (always the custodial parent in the case of a minor). This is witnessed by

the assessor or patient registrar. This document allows, among other things, to bill and receive payment directly from third party payers. When appropriate, Cumberland Heights will have the patients sign one or more of the following financial documents: 1) The **Financial Responsibility** form is used to notify the patient that there is a problem or a potential problem with their insurance coverage. This form is to be completed whenever Cumberland Heights is unable to verify insurance coverage or to pre-certify the case. The financial responsibility form is also to be completed: a) when insurance is possibly preexisting or otherwise limited; b)when the authorization has been denied and the patient is awaiting an appeal or agreeing to self pay the remaining treatment: c) or when patients who otherwise would have 100% insurance coverage are agreeing to be responsible for non-covered services. 2) The **Promissory Note** form is signed at the time of discharge when there is an outstanding balance and define the estimated balance the patient will owe along with a payment plan.

The financial advisor is charged with enrolling patients in the automated bank draft payment program. Cumberland Heights currently allows those accounts enrolled in the bank draft program to remain interest free. Interest does not accrue on accounts while insurance is pending or in the first 90 days after discharge from each level of care.

The financial advisor is responsible for completing an account worksheet on each patient's account(s) at/ or within 3 days of discharge. This form adjusts the gross revenue to the amount of each third party payer's contract. This worksheet specifies the time payment arrangements and prorates the account.

III. Insurance Collections

Accounts are billed to patients and any third party payers three days after discharge. A billing error report lists those accounts missing critical information and prevents them from being sent with incomplete data. A copy of the billing error report is given to the insurance benefit specialist and the Director of Patient Accounting each day. Diagnoses are entered by the transcriptionist -- all other corrections are the responsibility of the insurance benefit specialist.

Within 30 days, collection calls are made to third party payers concerning the status of the claims that have not been received. The insurance collector will work the account until a payment or denial is received. When the claim is pended for information from the insured, the insurance collector will send at least one letter and attempt one call to the patient. If the patient does not respond to the insurance company request, then the account will be changed to self pay collections and the patient will be pursued for the full balance.

Explanation of Benefits (EOB)'s are audited within 5 days after they are received. All outstanding EOB's are audited prior to the end of each month to ensure that all contractual adjustments have been made and that the discharged A/R is accurate.

The insurance collector is responsible for correcting any mistakes made on the initial contractual adjustment and resolving in variances with the EOB. Corrections are submitted to the Director of Patient Accounting for review and authorization prior to being keyed. The insurance collector is responsible for reporting reoccurring problems, as a result of the intake, utilization review, and insurance processes that may affect future claims, to the Director of Patient Accounting.

IV. Self Pay Collections

Self pay collectors monitor discharged patients accounts and attempt to enforce the patient's agreement to be responsible for the balance. The self pay collector will send collection letters and make collection calls in order to keep a patients account current. Each month a statement is sent to the guarantor on all active accounts.

The collector is allowed, within fairly broad guidelines, to alter payment plans of patients, including granting a grace period of no more than three months due to financial hardship. All such arrangements must have a specific end date. Open ended arrangements such as not making payments until insurance has paid are a violation of this policy. The collector may, from time to time, offer financial incentives for payment in full on accounts. Usually no more than 3-5% may be offered without first getting the approval of the Director of Patient Accounting or the CFO.

The guideline for placing an account for outside collection is three consecutive months of nonpayment after all third party payments have been received. An inconsistent payment, broken promises on accounts that previously where about to be placed, and statements that would lead the collector to believe that a patient will not pay their account, are also factors leading to outside collection. Generally, larger balance accounts and accounts with confirmed employment with the potential for garnishment will be placed with collection attorneys. The remaining accounts are placed with a collection agency.

An allowance for bad debt is reserved each month based on adjusted revenue less management contracts. Accounts are written off into bad debt by submitting the bad debt adjustment form or excel spreadsheet with documentation to the Director of Patient Accounting. No account is keyed into bad debt without this approval.

Accounts that are sent to outside collection, are in bankruptcy, or are uncollectible are written off against the bad debt allowance as they become known. Occasionally accounts that have been previously written off are placed into the worked write-off financial classes. Accounts are reviewed and slow pay accounts (current payment arrangements that will not pay off the balance in the next 20 months and payments are less than $100.00 per month) are written off into worked write-off financial classes. The collector may submit accounts to be written off as uncollectible if they believe the patient is indigent or we lack the proper documentation to pursue the claim any further.

When a bankruptcy is received a "proof of claim" for Chapter 13 cases will be submitted to the bankruptcy courts within a week of notification. All self pay collections are ceased including the sending of statements once the notice has been received. Both Chapter 13 and Chapter 7 cases are kept in a binder by alphabetical listing.

Refunds for overpayment of a patient's account are signed by two staff members then forwarded to the Director of Patient Accounting for approval. The second signer is held accountable for all refunds. All refunds are sent to the payor that made the overpayment. When both a patient and an individual other than the patient have made payments to an account, the refund is made to the individual first with any residual payment made to the patient. Under no circumstance is a payor refunded more than the payments which they have paid. When an insurance payor has paid incorrectly they will be notified by phone or by mail and allowed the opportunity to request a refund in writing. If no request is made within 6 months then an adjustment is made to the account in the amount of the overpayment and the action is noted in the patient comments in the computer.