VOLUSIA ENDOSCOPY AND SURGERY CENTER		
SUBJECT: PATIENT FINANCIAL COUNSELING & PAYMENT PLANS Page 1 of 2		
POLICY: BO-28	**EFFECTIVE DATE:**	**APPROVED BY:**
DATE REVIEWED:	**DATE REVISED:**	

PURPOSE
To describe parameters for appropriate, adequate and timely patient financial counseling.

POLICY
1. The Center has contracted with the Physician Practice to provide financial counseling for the Center.

2. Upon completion of insurance verification, the insurance verifier or designee will forward information regarding deductibles, co-pays, self-pays, etc. to the receptionist. The receptionist will collect any co-pays, deductibles, etc. on the day of surgery.

3. The patient financial counselor will contact the patient (or responsible party if the patient is a minor) at least three days but preferably one week prior to the date of procedure to inform the patient of his/her financial responsibility and respond to any and all questions regarding the patient's insurance coverage as determined during insurance verification for the scheduled procedure.

4. Co-pays and deductibles are due on the day of procedure.

5. Payment in full should be requested from the patient on the date of service. Payment can be made by cashier's check, credit card, money order, or cash.

6. Self-pay patients are expected to pay in full by the date of procedure.

7. If the patient refuses or cannot afford full payment on the date of service, a promissory note must be signed and the following payment plans may be offered, listed in the order of preference.
    a. 50% at admission and payment of the remaining 50% in three (3) equal monthly payments.
    b. 50% at admission, payment of the remaining 50% in six (6) equal monthly payments.
    c. Any promissory note extended over the six (6) months will need prior approval by the Administrator.

8. Any other payment arrangements must be made with the written approval of the administrator. No patient should be denied care without approval of the administrator or designee.

9. For services not covered by Medicare, the patient must be made aware of their responsibility and sign a properly completed Advanced Beneficiary Notice (ABN) or Notice of Exclusion of Medicare Benefits (NEMB). *(See Financial Policy - Medicare).*

PROCEDURE
1. Contact the patient at least three days prior to procedure.

2. Be aware of any unusual circumstances that may require additional information from the patient, e.g. second opinion, proof of full-time student status, etc.

3. If the patient states that he/she cannot pay the deductible amount due, even after being offered credit card payment, negotiate a promissory note with the patient based on guidelines on #7 above. ***Please note that a recurring credit card payment may also be accepted for promissory note terms. If the patient selects this method of making monthly payments, complete both the appropriate promissory note and recurring credit card payment form.*** If the patient cannot meet this level payment, advise him/her that you will call back after speaking with a manager.

4. If the patient claims inability to make payment of any kind, refer the account to the business office coordinator/administrator.

5. Upon the patient's arrival on the date of service, the patient should complete all necessary paperwork, offer his/her insurance card and identification for copying, sign the promissory note, remit the agreed upon payment, and receive a receipt for any payment.

6. The patient should receive a copy of any consent forms, release of information forms, and assignment of benefits forms they sign, as well as a copy of the promissory note, if applicable. They should also receive instruction as to whom to contact if they have further questions about their insurance or payments due.

7. A copy of the promissory note, insurance card (front and back), and patient's identification must be forwarded to the billing staff member. *If insurance cards are scanned into software, it is not necessary to forward copies to the billing staff member.*

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SUBJECT: CHARITABLE CONSIDERATION Page 1 of 3		
POLICY: BO-19	**EFFECTIVE DATE:**	**APPROVED BY:**
DATE REVIEWED:	**DATE REVISED:**	

Purpose:

1. To define the rules and methods to determine which of the Center's patients are eligible for financial assistance

Policy:

1. The Center's Financial Assistance program can be approved only after all other financial and third-party resources are exhausted.

2. Eligible services are those services provided by the Center and are considered covered services by the Medicare program. Total system accounts with balances of $100 or less are not eligible for Financial Assistance adjustments. Co-pays are not eligible since these should be paid for at the time of service.

3. Patients have a responsibility to inform the Center of their need for financial assistance, supply the information required and complete the application, and to cooperate to the best of their ability with the application process. Patients who do not take the responsibility to contact the Center in a timely manner will have their account processed via the routine collection process. Refusing to supply the information or falsifying information on the application will result in denial of the application.

4. Patients who are unable to complete the application will be provided assistance to do so.

5. Patients who are approved for a Financial Assistance discount and do not make payment, will be processed via the routine collection process for the portion for which they are responsible.

6. Financial Assistance discounts may be applied to services provided up to six months following the date of approval. At that time, if a financial need still exists, the patients must reapply.

7. The Center reserves the right to change the benefit determination if financial circumstances change or additional information is obtained.

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SUBJECT: CHARITABLE CONSIDERATION Page 2 of 3		
POLICY: BO-19	**EFFECTIVE DATE:**	**APPROVED BY:**
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Procedure:

1. Patients expressing concerns about their ability to pay for services received from the Center will be offered information about the Financial Assistance program and, if requested a Financial Assistance application.

2. The following are required to process a Financial Assistance request:
    a. The completed application.
    b. Proof of any or all of the following that apply.
        1) Employment income including the most recent (3) three paystubs, or a letter from the employer indicating gross earnings.
        2) Unemployment compensation earnings.
        3) Monthly benefit amount of any assistance or maintenance payments such as child support, alimony, housing allowance, food stamps, etc.
        4) Pension received for the last three months.
        5) Social security or disability income.

    c. A copy of the most recent federal income tax form (1040) including all schedules.

3. The information requested in #2 above should be the patient's information if the patient is 18 or older. If younger than 18, it should be the guarantor's information.

4. Applications will be processed within 15 business days of receipt of a completed application. All patients will be notified in writing of the results of their application.

5. If the application is not complete, the patient will be notified in writing and the additional information will be requested. Patients will be offered the option of assistance in completing the application at this time. Patients not responding with the necessary information in a timely manner will have their account follow our normal collection process.

6. Patients will continue to receive statements while the application is being processed.

7. The Administrator in conjunction with the Medical Director will approve or deny accounts with adjustments greater than $10,000.

8. Notes regarding the results of the Financial Assistance application and decision will be made in the billing system. The note will include:
    a. Date of receipt of application.
    b. Date approved or denied.
    c. Discount approved.

9. Financial Assistance applications will be kept on file for seven (7) years before being destroyed.

10. The Center will review the patient's income to determine eligibility in the amount of financial assistance.

    a. Patients with incomes between 100% and 150% of the federal poverty guidelines will receive a facility fee reduction to 80% of the Medicare allowable fee.

    b. Patients with incomes below 100% of the federal poverty guideline will receive a facility fee reduction to 60% of the Medicare allowable fee.

    c. Payment due at time of service.

VOLUSIA ENDOSCOPY AND SURGERY CENTER
CHARITY CARE APPLICATION

Please complete all sections of the application.
Once completed, please return, along with requested documents to:
Carleen Bingham-Administrator
VOLUSIA ENDOSCOPY AND SURGERY CENTER
550 Memorial Circle- Suite H
Ormond Beach, FL 32174
If you have any questions, please call 386-672-0017

Date of Service:	Chart Number:
Patient Name:	
Guarantor (if different than patient):	
Guarantor's relationship to patient:	

Enter Patient/Guarantor Information Below

Street Address:	
City, State, Zip:	
Home Phone:	Work Phone:
Employer:	
Employer's Address:	
Spouse:	
Spouse's Employer:	
Spouse's Employer's Address:	
Patient/Guarantor SS #:	Spouse's SS #:

Information on all others living in Patient/Guarantor household
Use additional sheet of paper if necessary

Name	Relation	DOB	Source of Income/Employer	Wage/Week

VOLUSIA ENDOSCOPY AND SURGERY CENTER
CHARITY CARE APPLICATION
ADDITIONAL INFORMATION REQUIRED

Please return the completed application with all requested information attached.

1. Copy of true, signed income tax return for the previous tax year for each wage earner in the household.

2. If a wage earner did not file a tax return for the previous tax year, a completed "Affidavit of Non-Filing Status" needs to be completed, signed, and notarized.

3. A copy of the last three pay stubs for each wage earner currently residing in household.

4. A copy of any letters of unemployment awards issued to anyone currently residing in household.

5. A copy of any disability awards issued to anyone currently residing in household.

6. If anyone currently residing in the household is retired, a copy of any Social Security checks, and/or pension checks, and/or retirement accounts disbursement checks.

Please add additional information which you feel is necessary to complete our evaluation.

You will be advised as to the status of your application within ten working days of its receipt in our facility. Please feel free to contact us at any time if you have any questions regarding this application.

PLEASE NOTE: *You may be asked to cooperate in an attempt to secure a source of payment outside of this facility in order to cover your account at this facility. These sources may include Medicaid, fraternal organizations, community assistance programs, or any other recognizable charitable organization. Refusal to cooperate may result in denial of this application.*

All of the information received in regard to this application will be held in strictest confidence, per the guidelines set forth in the Federal Patient Bill of Rights.

Signature of Patient/Guarantor:	Date:
Witness of Signature:	Date:

Please feel free to make and keep a copy of this completed form for your own records. If you cannot make a copy, please deliver completed application to the facility and we will make a copy for you.

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SUBJECT: COLLECTIONS Page 1 of 4		
POLICY: BO-36	**EFFECTIVE DATE:**	**APPROVED BY:**
DATE REVIEWED:	**DATE REVISED:**	

PURPOSE

To describe parameters for appropriate collections activity

POLICY

1. The Center has contracted with the Physician practice to perform billing and collection services for the Surgery Centers.

2. Collection activities should be governed by the following standards:
   a. Every account with an outstanding balance should be followed up (and the follow up documented in the computer system) at least every 30 days.
   b. Accounts should be worked by priority of age and value.
   c. Accounts receivable days should be maintained at less than 55 days in receivable on average. (To calculate days in A/R take the last 3 months net revenue, divide by the total calendar days in that time to get the average net revenue per day, then take the total net A/R for the current month end and divide by the average net revenue per day.)
   d. Accounts receivable over 120 days should be no more than 10% of the total A/R balance.
   e. Fair Debt Collection Practices and professionalism should be observed in all collection communications.

PROCEDURES

General

1. Print reminder notes from the computer system for the day. Prioritize and perform the appropriate action whether that is a call to a patient or insurance company, sending a statement or letter to the patient, or re-filing insurance (correcting information as needed). Other possible actions include placing the account on the Bad Debt Write Off list, performing a small balance write off (if the account is less than $10), or placing the account on the Collection Agency Turnover list for the administrator to review.

2. Follow up on the previous day's activities to assure faxes were received, telephone calls were returned, etc.

3. Review list of accounts receivable by payer, so that more than one outstanding insurance balance can be worked during one contact.

4. All actions taken should be documented in the computer system. The account should not be considered "worked" unless some action that will move the account toward resolution has taken place.

5. Each contact should be a new memo that includes the date, the person with whom you spoke, the results of the discussion, a future follow up date dictated by the resolution achieved, and your initials. Abbreviations should be used but only those agreed upon and documented by the business office coordinator.

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SUBJECT: COLLECTIONS Page 2 of 4		
POLICY: BO-36	**EFFECTIVE DATE:**	**APPROVED BY:**
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Insurance

1. If the insurance company representative states that the claim has been paid but the check has not yet been received, verify the mailing address and tax identification number, obtain the date of the check, the check number and amount. The payment may have been posted in error to another account.

2. The insurance collections process should begin at 35 days after the claim was filed. The collector should place a call to the insurance company to determine the status of the claim. If the claim is in process, ask for an estimated payment date and enter a follow up note for that date in the tickler system.

3. If the claim has not been received, ask if it can be faxed. If you fax a claim, follow up with a telephone call to verify it was received. Again, enter a follow up note in the tickler system.

4. If the claim is in review, determine what information is required to satisfy the review. If it is physician notes or any other item that you can obtain from the patient's chart, fax the information to the claim reviewer and ask for an estimate of when payment will be made.

5. If the claim has been denied, ask why. If it is a documentation problem, work with the coder or whoever can assist to get the claim re-filed and paid.

6. If the claim is denied for timely filing, verify this is valid in our contract with the payer. If so, add it to the list of accounts to be written off for the business office coordinator to review.

7. Medicare or any other claims that are filed electronically should be reviewed at 20 days after the claim was filed.

8. Do not hesitate to contact the plan's Provider Representative if you believe the claim processing is being delayed without reason.

9. Diligent follow up is critical to avoid claims denied due to filing after the carrier's established timely filing window.

10. Finally, enlist the patient's assistance in getting their claim processed. We file the claim with their insurance company as a service to them, however, our relationship and contract is with the patient, not the insurer. Patient calls to their insurance company can be very effective in getting a delayed claim paid.

Patient Collections/Statements/Dunning Letters

1. Patient statements should have standard dunning messages based on the age and status of the claim. Some possible options, depending on how your computer system ages the accounts, how it determines the need for a statement and how it handles patient vs. insurance balances are:
    a. 30 Days Old – We have filed your insurance claim for you.
    b. 60 Days Old – Your insurance has not paid your claim. Please contact your insurance carrier.
    c. 90 Days Old -- Your insurance has still not paid. Please contact our billing office to discuss payment of your claim.

d. Over 90 Days Old – For claims more than 90 days old, begin sending one of the standard dunning letters as appropriate to the situation. See the following sample dunning letters that may be used. Note: Confidentiality must be observed when sending dunning letters. Assure that only the name and address show through if window envelopes are used. The envelope must be sealed.

e. Over 120 Days Old – All accounts over 120 days old should be referred to the business office coordinator for review and possible turnover to a collections agency. Exceptions to this action include Medicare/Medicaid, CHAMPUS, Worker's Compensation and some HMO accounts.

2. Per Florida regulations an initial post-treatment statement will be sent seven (7) days after the DOS.
   a. This statement will prominently display the Center's patient liaison name and telephone number.
   b. If the patient requests their medical record to verify the charges, the Center must send the medical record to the patient within 10 days from the request.
   c. If the patient has any questions regarding their statement or bill, the Center is required to respond within seven (7) days after the date a question is received.

3. Subsequent patient statements should be sent at least monthly, or upon the various "triggers" your computer system may use.

Insufficient Funds/Bankruptcy/Litigation/Caveats

1. When a patient's check is returned from the bank for insufficient funds, the patient should be contacted immediately. Verify with your bank that they attempted to clear the check twice. When you call the patient, offer them the opportunity to clear the past due amount immediately by credit card payment, which can be taken over the telephone, by money order (set a date for receipt and follow up), by cashier's check or by bringing cash to the Center.

2. Bankruptcy notices require immediate attention. Prompt filing with the bankruptcy court is very important. Do not continue to send the patient statements or dunning letters while the bankruptcy is being processed.

3. Account balances that become part of litigation can be particularly difficult to collect in a timely manner. Patients are unlikely to want to pay on these claims until the case is settled. A letter of protection or lien may be obtained from the patient's attorney. Continue to follow up with the attorney monthly.

4. A caveat may be filed in your county probate court for patient balances that remain after you have been notified that the patient is deceased. Both the business office coordinator and the administrator should approve this action before it is taken. A form for your state may be obtained from the State Probate Office. If the caveat is returned stating that estate benefits have been exhausted, the account should be written off to bad debt.

Collection Agency Referrals

1. Before an account is put on the collection agency list, which must be reviewed and approved by both the business office coordinator and Center administrator, the following should occur:
   a. Statements should have been sent at least monthly;

b. Two telephone contact attempts should have been made and documented;
c. Three dunning letters, including a final notice that the account will be placed with a collection agency in ten days if payment is not received.
d. Discovery that a patient gave false information, has moved with no forwarding address and cannot be contacted through employment or relatives, has written checks on a closed account, has not repaid an NSF check within 10 days, or has kept a payment made by the insurance company are all items that may trigger referral to a collection agency.
e. Collection agency accounts should continue to be monitored every 30 days until it collected or it is evident that further collection attempts would be unsuccessful.

2. Sufficient information (patient ledger, tickler note entries, copies of all letters should be provided to the collection agency.

3. Once an account is forwarded to a collection agency, all communication from the procedure center/billing office must stop. This includes any written communications as well as telephone contacts.

4. If a payment is received on a collection agency account:
   a. Do a correction of write-off for the full amount that the patient paid to the agency. Correction is labeled "collection payment received".
   b. Apply payment equal to the actual money sent to the center from the agency (patient payment minus agency commission). Payment is labeled "payment from collections".
   c. Apply write-off equal to commission withheld by agency. Label write-off "collections expense".
   d. Account should equal zero again.

5. Uncollectible accounts for balances under $10 should be written off to bad debt and should not be placed with a collection agency.