LRGHealthcare

Lakes Region General Hospital,
Franklin Regional Hospital,

and

Affiliated Provider Practices

Credit and Collection
Policies and Procedures

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TABLE OF CONTENTS

I. INTRODUCTION

A. Purpose/General Policy

It is the policy of LRGHealthcare to maintain a sound financial operation to facilitate and support on a continuing basis, the rendering of quality health care. To ensure that the organization provides the necessary services, the Patient Financial Services Department must assure timely billing and collection of all payments due from patients and/or third party payors to maintain an adequate flow of cash and an acceptable level of patient account receivables.

This Credit and Collection Policy will serve to stipulate the LRGHealthcare's parameters for fair and equitable dealings with its patients, their guarantors and third party payors. These policies are uniformly applicable to all persons regardless of race, color, national origin, alienage, religion, creed, sex or age.

B. LRGHealthcare Mission

LRGHealthcare's mission is to provide, quality, compassionate care and to strengthen the well-being of our community. LRGHealthcare will fulfill its goals and charitable mission and deliver coordinated quality health care to all patients it serves by offering services that:

1. Are available, affordable, accessible, and appropriate to the needs of the population/community.
2. Have the professional and technical expertise and facilities to deliver coordinated quality health care.
3. Are continually assessed for improvement.
4. Are a financially sound use of the funds for which it has stewardship.
5. Can be delivered in a financially responsible manner.
6. Contribute or protect LRGHealthcare's ability to make essential health care available and accessible.
7. Are integrated with community agencies and other healthcare related institutions to the extent possible to avoid unnecessary duplication of services and to facilitate access and coordination of care for patients and their families.

II. DELIVERY OF HEALTHCARE SERVICES

A. Emergent and EMTALA level Care Service

Any patient who comes to our Emergency Department services shall be evaluated as to the level of emergency services needed without regard to patient's identification, insurance coverage, or ability to pay.

B. Non-Emergent, Non-Urgent Services

For patients seeking non- emergent, non –urgent care a deposit or payment of out of pocket expenses will be expected at time of service.

C. Avoidable Elective Care

Any scheduled service will be screened for financial payment prior to services. Determination of required payment will be determined by necessity of service, ability to pay, payment history and clinical documentation.

D. Employees

We reserve the right to handle employee services/account resolution outside of this policy but within the scope of LRGHealthcare vision to care for its employees.

E. Locations of Care

LRGHealthcare policy applies to all locations where patients may seek care to include but not limited to: Lakes Region General Hospital, Franklin Regional Hospital, Interlake's Ancillary Services, Hillside Ambulatory Center, Laconia Clinic and affiliated provider practices, Ancillary Services located offsite or provided offsite.

III. FINANCIAL ASSISTANCE POLICY

A. Financial Counseling

Financial Counselors are available to any patient who wishes to discuss cost of treatment and/or payment. LRGHealthcare will make every attempt to visit any self-pay inpatient to discuss coverage and payment options.

Financial Counselors will try to identify coverage options for patients who may be under or uninsured. They will also assist patients in applying for coverage through the following means to include but not limited to: direct enrollment, referral to outside contracting agencies, referral to state and federal medical resources, agency resources, internal referral to the Enrollment Coordinator or Self Pay staff.

The financial counseling process includes, but is not necessarily limited to the following:

1. The acquisition and/or verification of demographic and financial data either prior to admission/service, at the time of admission/service, or when the patient is hospitalized/treated.
2. The analysis, either prior to or immediately after the date of admission/service, of demographic and financial data will be used to determine how to process the patient accounts in the most advantageous manner for both the organization and patient.
3. The arrangement of payment terms within the parameters specified under collection guidelines.
4. The calculation and collection of pre-service deposits for amounts identified as patient responsibility (including deductible and coinsurance), within the parameters specified in "Pre-Admission/Pre-Treatment Deposits" policy.
5. The identification of delinquent or bad debt balances on previous accounts to determine resources for liquidating the combined balances with the patient/guarantor at the time of the patient/guarantor contact.
6. If a patient requires emergency or urgent services the Financial Counselor shall process the patient as expeditiously as possible for those services without regard to up-front payment.
7. All scheduled avoidable elective services where the patient refuses or is unable to pay or make payment arrangements shall be referred for financial counseling. The financial counselor shall defer and/or cancel services until such time as the patient makes payment arrangements.
8. All avoidable elective surgical procedures shall be reviewed for payment prior to scheduling.

For patient out of pocket expenses exceeding established amounts the services will be evaluated on a case by case basis and follow the Patient Payment/Collection Policy for Hospital Services.

B. Price Quotes

LRGHealthcare will provide any patient, with a minimum of two days' notice and required information, a quote for expected out of pocket expenses based upon the information given. If requested, that can be provided in writing

C. Financial Assistance (including patient discounts)

See Financial Assistance Policy

IV. ACQUISITION OF PATIENT INFORMATION

A. Collection of Patient Data for Billing and Collection Purposes

a. Patient Responsibility:

Prior to the delivery of any health care services or immediately upon becoming aware of changes in information (except emergency services), the patient is expected to provide timely and accurate information regarding their: insurance coverage, demographic information, income/financial status. This information shall include ANY information which may be necessary for accurate patient identification and timely billing for services.

It is ultimately the patient's obligation to keep track of status of insurance and/or patient claim and timely pay any outstanding balances due LRGHealthcare. Patients are also required to notify outside state and federal agencies through which they are receiving services. This shall include but not limited to encounters in which the patient does not provide insurance information timely. If they do provide it after filing limits have expired, it will be patient responsibility and we will not bill for services.

The patient and/or legal guarantor is ultimately responsible to pay for all charges incurred regardless of insurance coverage, unless specifically prohibited by Federal or State laws or regulations (e.g. patients covered by Medicaid). The person signing or giving verbal or written consent for the Payment Guarantee and the Consent to Treatment forms will be held responsible for payment

b. LRGHealthcare Responsibility

LRGHealthcare staff will make all reasonable efforts to collect patient insurance, consents and other information to verify coverage for services provided. Reasonable efforts shall include but are not limited to: requesting insurance and demographic information from the patient/guarantor, checking any available public or private databases, following all known billing rules of the third party payers. This information may be obtained and screened prior to services rendered for scheduled services and at time of service for non-scheduled services.

If the patient/guarantor is unable to provide necessary information, and patient consents, reasonable efforts will be made to contact relatives, friends, guardians, or other appropriate parties to obtain the information.

LRGHealthcare will also make reasonable efforts to determine if the service is covered by a third party payer and advise the patient. However, it is ultimately the patients' responsibility to know their coverage benefits.

B. Insurance Verification

a. The LRGHealthcare staff members will perform pre-admission review for non-emergency patients booked for services in advance of the scheduled date of admission/service. The Insurance Verification Specialist will also perform post admission review and benefit verification for emergency and direct admissions as well as short observation stays. At the same time, they will assess the need for an authorization. If the service does not require one, it will be documented. If an authorization is needed and has been obtained the authorization number will be documented. If one is needed and has not been obtained the Insurance Verification Specialist will refer the service back to the office to be obtained. The service will then be delayed until the appropriate authorizations have been obtained and documented.

b. In-house transfers, status changes and outside transfers will be reviewed and authorized by Care Management.

c. The Pre – Registration staff will attempt to collect all patient out of pocket expenses for scheduled services prior to services being rendered. If the patient indicates that they are unable to pay or make a deposit according to current collection guidelines, they will be referred to a Financial Counselor.

d. For non-scheduled date of service care, Patient Access staff will attempt to obtain accurate information pertaining to services at the time of registration. This may be done by direct patient query or using third party database and web based information portals.

e. For Insurance verification and pre-authorization related to any department not processed by Patient Access refer to their specific departmental policies.

C. Guarantor Credit Scoring/Account Assignment

Where applicable, LRGHealthcare may use automated credit scoring tools to assist in making determinations regarding patient's ability and propensity to pay to more accurately and efficiently assign accounts for designation as possible charity care. In some cases, this will be done automatically based on the service, account balance and patient coverage information. In other cases, it will be pulled on an individual basis when trying to make determinations about an account or at the request of assistance from the patient.

V. Insurance Billing and Receivables Management

LRGHealthcare will expedite the timely processing of claims to third party payers. However, the patient and/or legal guardian is ultimately responsible to pay for all charges unless specifically prohibited by Federal or State laws or regulations (e.g. patients covered by Medicaid). In the case of minors, the responsible party signing the Payment Guarantee and the Consent to Treatment forms will be held responsible for payment.

A. Medical Insurance Billing

a. Federal and State Billing and Processing

LRGHealthcare will bill federal and state insurances in accordance with federal and state rules, regulations and guidelines for those we participate with.

b. Contracted Insurance Billing and Processing

LRGHealthcare will bill contracted insurances in accordance with the specific contract guidelines and rules.

c. Non-Contracting Insurance Billing and Processing

LRGHealthcare will make reasonable attempts to bill and assist with insurance claim resolution. However, account resolution to include but not limited to: prior authorizations, notifications, coverage/benefits, timely filing and payment are ultimately the patient/guarantor's responsibility.

B. Insurance Follow Up/Denial Management

It is LRGHealthcare's expectation that claims submitted to third party payors be adjudicated in a timely manner. When payment in full, less any applicable deductibles, co-insurance or co-payments, is not received, Patient Financial Services staff is required to follow up on applicable patient account(s).

a. If correspondence such as: remittance advice, explanation of benefits, letters, non-remittance advice rejections or suspensions or partial payment is received.

i. Correspondence will be processed on a daily basis as time allows. The appropriate billing systems in accordance with job responsibilities will be checked for other applicable accounts and changes to the accounts will be made as necessary.

ii. Requests for information will be sent to other departments through system generated work queues. The expectation is that the departments will work these items within two business days. If they are unable to meet these deadlines it is their responsibility to reach out to the Director or Manager of PFS. All follow-up activity will be noted on the appropriate patient account(s).

b. Work Queues will be used to determine those payers whose claims need additional follow up activity performed:

1. The appropriate Manager or designee will assign follow up activity to Patient Financial Services staff through established routines.

2. Every attempt will be made for the first follow up activity to occur around 45 days after submission of the claim.
3. All subsequent follow up will be done based on initial findings and as time allows.
4. When multiple accounts for one patient exist and remain unpaid by the same payer, all of the accounts will be addressed regardless of account age or balance on the account.

c. Insurance Recovery Efforts are exhausted by following policy in V. B. b
Account balances will then be transferred to the self-pay category. Balance transfer to self-pay is only permitted after a full explanation of the reason for transfer is noted on the account

d. Late Charges – Will be bill in accordance Late Charge Desk Procedure.

C. Medicare/Medicaid Bundling Identification/Process

a. 72 Hour Inpatient Bundling –all services three days prior to an inpatient stay

The Patient Financial Services Department will insure that all applicable outpatient services are bundled appropriately into inpatient services according to CMS regulation. The Patient Financial Services designated staff member will be responsible for having an understanding of the CMS regulations and how to apply them properly to this process to insure accuracy and compliance. The designated billers are also responsible for reporting any recognized process deficiencies. This is accomplished via desktop procedures.

b. 24 Hour Report – any facility services provided on same day.

The Patient Financial Services Department will insure that services rendered for the same date of service will be billed as one claim according to CMS regulation. The Patient Financial Services designated staff member will be responsible for having an understanding of the CMS regulations and how to apply them properly to this process to insure accuracy and compliance. This will be accomplished via desktop procedures.

c. Other Bundling Rules – will be followed according to contract terms.

D. Bundling of Ambulance Transport and Other Charges

When applicable by: insurance contract, federal and state guidelines and or self-pay exception (as identified by the Director of QA/UR), we will combine the ambulance and/or other outside healthcare charges with the LRGHealthcare inpatient stay claim. We will be responsible for payment directly to the provider of ambulance/transport and/or other outside healthcare services.

Once the Patient Financial Services Department has been notified of a patient who needs ambulance transport and/or other outside healthcare services, there must be proper charging of the patient account.

E.SNF Consolidated Billing

a. When indicated by federal and/or state regulation, all appropriate services will be identified and billed to the respective skilled nursing facility within 5 days of the beginning of the next month. These services will be identified based on the information provided by the skilled facility to LRGHealthcare upon ordering/scheduling the service. It is the skilled facilities responsibility to provide accurate information which to abide by federal and state billing regulations.

b. All reimbursement will be according to contracted/negotiated rates and terms.

F. Discounts to Insurance Carriers

Discounts may be given only to non-contract primary insurance carriers. The following criteria are recommended before accepting payment minus the discount:

- Discount allowed up to 10%.
- There will be no charge audit performed on the account by the insurance carrier.
- The insurance carrier will not be held liable for any late charges.
- If the discount is accepted by the payer, it must be received in the Patient Financial Services department within ten (10) business days of the signed agreement. If payment is not received within designated time frame we reserve the right to revoke discount.

- Only a Vice President, Director or designated Representative within the Contracting or Patient Financial Services shall be authorized to accept discounts.

G. Provider Liable

Contracted and government insurances expect Hospital/Physician's to follow specific guidelines before providing services to their members. If the guidelines have not been followed the carrier will deny the claim. The denial reason will be indicated on the remit along with a notation that the patient may not be billed which indicates the charge is provider liable. Staff should follow the LRGH Write –Off Desk Policy for more instructions.

a. All provider liable charges will be researched and appeals will be submitted or claim rebilled with changes as appropriate. When indicated, assistance will be provided by the Care Management Team and/or respective department.

b. When all efforts have been exhausted and we concur that the charges are provider liable, the Patient Financial Services staff documents the encounter and identifies a work item for provider liable review.

c. Provider Liable Write Off.

1. PFS staff can write off balances under $100 without management approval
2. PFS Billing Manager may approve write-offs on balances from $100 to $4999.
3. The Director of Patient Financial Services will approve write-offs on balances greater than $5,000.
4. Surgical assists do not need to go through the management approval process. These can be adjusted off by staff using alias code 5028.

d. Employee financial class Employee (PC EM) – for no diagnosis to warrant denials that are hospital responsibility the PFS staff can adjust of balances under $100 without going through the management approval process to alias code 5026.

VI. Third Party Billing

B. Agency Billing

At the request of area businesses, we will consolidate charges for employee services to a monthly invoice at negotiated rates. Businesses will be billed monthly in the subsequent month to services rendered. Payment is expected within 30 days of bill date.

C. Employer GPS Billing

Employer GPS is a program that is offered in partnership with an outside insurance agency to employers only. This program is not valid outside the LRGHealthcare network.

LRGHealthcare will participate with employers to offer employer discounts on patient out of pocket liability that the employer group is covering.

- Works with any commercial health insurance with whom LRGHealthcare has a contract
- Requires that the employer group have a Section 105 HRA plan
- Requires that the employer group fund at least half of the large deductible under the HRA plan
- Requires that HRA plan administrator process all HRA claims and interface with LRGHealthcare on employees' behalf for payment of claims
- Requires that employer pay the HRA claim to LRGHealthcare within 14 days of receipt of amount due
- Requires that HRA plan administrator develop an ID Card that must be used by the employees when obtaining services at LRGHealthcare provider locations to ensure appropriate application of program benefit.

D. Out of Country Insurance

LRGHealthcare does not bill any insurance that processes claims' outside of the United States.

At the request of the patient/guarantor an itemized bill will be provided for patient to submit for insurance processing. These patients are considered self-pay.

E. Other Specialized Third Party Billing

Policies will be implemented to accommodate specialized billing circumstances when appropriate.

VII. Cash Processing

A. Departmental Cash Processing

All monies (of any tender) when received, at any location, shall be secured by the recipient in designated secure location according departmental policy and procedure. Monies will be tallied, balanced and safely secured until they are transported to Cash Posting in in the Account Resolution Department with related documentation by approved, designated individual. Any funds received shall be transported to Cash Posting within one business day.

Each department that receives monies shall secure cash as determined by their internal departmental cash controls in compliance with the LRGHealthcare Cash Controls policy issued of Finance.

B. Cash Controls

Cash Coordinators must process and deposit all monies on date of receipt or next business day dependent on time of receipt. All monies must be posted by ARD cash team on the next business day after deposit except end of month where it must be posted on the same day.

Any variances must be reported immediately to a manager.

Reference full LRGHealthcare Cash Control/Posting policy – Finance Department.

VIII. Credit Balances

Credit balances can be due to insurance and/or patient overpayment of charges or posting error. Because of this, all credits must be thoroughly researched to determine the reason for the credit balance. See desktop procedure. They will be addressed based on what type of credit it is:

A. Patient Credits

When a credit is identified as due to the patient, Patient Financial Service staff shall research to see if there are other outstanding accounts with self-pay balances due. If other open self-pay accounts are identified, the credit balance will be transferred to any other LRGHealthcare account or accounts that we bill for if deemed appropriate. If no other outstanding self- pay accounts are identified, a refund will be processed to the appropriate party. When appropriate, any prior adjustment may be reversed and credit posted to cover that balance.

Every attempt will be made to contact the patient for any outstanding credit balance and/or uncashed check sent as a result of a credit balance. If it remains outstanding, PFS staff will follow Abandoned Property Policy Guidelines.

B. Commercial Insurance Credits

When a credit is identified as due to a commercial insurance company within eighteen (18) months of the last payment, Patient Financial Services staff shall reimburse via check or submit a request for recoupment/offset based on based on insurance company policy.

All commercial insurance credit balances identified beyond eighteen (18) months or those returned to LRGHealthcare will be processed as income. (See SB 415-6)

C. Medicare/Medicaid Credits

When a credit is identified as due to Medicare or Medicaid, Patient Financial Services staff shall initiate the appropriate retraction process. Refunds will be processed in accordance Federal guidelines. In addition, Patient Financial Services staff shall submit the mandated quarterly credit balance reports for both payers by the last day of the month following the end of each quarter. These are approved by the Director of Finance.

D. Refund Approval

PFS Staff is required to research the overpayment to determine if it is due to a payment or and adjustment. They must document on the encounter the findings. If management approval is needed

they will identify a work item as indicated below. Check request approvals will be generated as follows:

- **0.01 to $249.99 staff approves**
- **$250.00 to $4,999 PFS Manager approves**
- **$5,000 and above approved by PFS Director**

IX. Account Adjustments

A. Administrative Adjustments

These are adjustments to accounts that are outside the standard departmental processing of accounts. Administrative adjustments may be requested by any management level employee to one of the PFS or ARD Management Team. For finalization, these adjustments require the approval of the PFS Billing Manager and/or the ARD or PFS Department Director.

B. Risk Management for Patient Billing Adjustments

Any adjustments to a patient's bill associated with a medical quality complaint shall be authorized by the Director of Risk Management and Safety. This will ensure that patient bill adjustments related to a medical quality complaint cannot be used as evidence of acknowledged liability in any subsequent malpractice action. Failure to follow the policy and procedure could result in denial of indemnification on the basis of prejudice in violation of the Hospital's insurance contract.

C. Financial Assistance

Accounts with a date of service prior to the date that a patient becomes eligible for NH Medicaid, may also be eligible for a charity care adjustment as long as the service is within in the current fiscal year and active accounts receivable.

If a patient is eligible for out of state Medicaid, accounts may be eligible for Charity Care adjustment.

D. Small Balance Write- Offs

All accounts that meet the small balance adjustment amount will be manually or automatically adjusted to zero balance on a weekly basis.

The balance requirement are as follows:

Encounters with a balance of $4.99 and under will be adjusted off to small balance write off. The system is programmed to take this adjustment automatically.

X. Self Pay Collections

A. Self-Pay Rates/Discounts

All self-pay patients (uninsured) are eligible for a minimum discount to be determined by the most current financial assistance policy. Additional self-pay discounts may apply depending on the services received. In addition, there are services such as but not limited to: Some provider visits, surgical procedures and specialty services that have discounted flat rates. Detail on specific discounts can be found in the Financial Assistance Policy.

B. Payment Responsibility

a. Liability and Accidents

These services will be treated as self-pay (see self- pay billing). Under special circumstances according to State of NH Department of Insurance regulations, LRGHealthcare will assist the patient/guarantor in billing the third party and/or health insurance. LRGHealthcare staff will obtain medical insurance info if applicable in case of liability is denied.

b. Avoidable Elective Care

Services that are deemed Avoidable Elective Care by LRGHealthcare representatives must be financially cleared prior to receiving services. In addition, LRGHealthcare reserves the right to defer or cancel said services. See Patient Payment/Collection Policy for Hospital Services.

C. Cash Collections at Time of Registration/Service

All patient out of pocket expenses or a reasonable deposit of those expected expenses as determined by LRGHealthcare are required prior to or at time of service. If a patient/guarantor is unable to make required payment for services deemed unavoidable/medically necessary, we will consider for hardship with appropriate application and documentation. (see Financial Assistance Policy)

D. Pre Payment of Non-Covered Services

If patient/guarantor insurance has indicated that a service will be non-covered, the patient/guarantor may be expected to make payment in full prior to services being rendered. In addition, depending on the insurance, they will be required to sign either an Advanced Beneficiary Notice (Medicare), or appropriate non-covered documentation.

F. Collection Process/Statement Process

a. Uninsured (True Self Pay)

LRGHealthcare will begin the statement billing process as soon as the account has dropped to Accounts Receivable status. When accurate demographics are provided, the guarantor will receive a minimum of three statements and depending on account balance may also receive up to two phone calls. Statement activity may be altered if we receive return mail and cannot find an accurate current address.

The statement activity shall occur at regular intervals up to the 120th day from the first statement.

b. Insured Patients

LRGHealthcare will begin statement process once the claim adjudication process is complete. At that time it will follow the same process as the Uninsured (see X,E,a)

G. Estates of Deceased Debtors – State of NH Only

LRGHealthcare will research with NH Probate Court for verification of existing estate and appointed executor.

a. Existing Estate

The guarantor of all appropriate accounts will be changed to: Estate of (patient).

All accounts will then be billed according to uninsured statement process (see X,E,a)

b. No Estate or no information regarding an Estate

LRGHealthcare will automatically consider these account for charitable care re-classification based on: electronic determination using software that provides medical credit scoring and ability to pay, or financial documentation provided by patient's family and/or attorney.

G. Hospital Liens in Personal Injury Cases

LRGHealthcare may have a lien on any third party or personal injury proceeds of the patient for the reasonable and necessary charges of the hospital in the treatment, care and maintenance of an injured person per RSA 448-A:2. This regulation provides that the notice of the lien must be provided in writing to 1) the person or persons alleged to be liable to the injured patient for the injuries and 2) to any insurance carrier which had insured such person, firm, or corporation against such liability, prior to the payment of any monies to the injured person or his attorneys or legal representatives as compensation for the injuries. Notice of the lien must be given no later than ten days after the patient has been discharged from the hospital and prior to the payment of any monies to the injured person in compensation for the injuries. The notice must include the patient's name and address, date of the accident, name and location of the Hospital, and the name of the person(s) or entities allegedly liable for the

injuries. The notice to the person(s) or entities allegedly liable for the injuries and/or the insurance carrier shall be made by registered mail, return receipt requested, and a copy shall be filed with the Clerk of the city of Laconia. If the insurance carrier (or responsible party) fails to honor a valid lien, the hospital has one year from the date of the improper payment to the patient to commence an action against the insurance company (or responsible party for the violation of the statute. Essentially, it is a one-year statute of limitations against the insurer or responsible party.

H.Payment Plans

LRGHealthcare's policy is that we will extend interest free loans for a maximum period of ~~24~~ 24 months depending on the account balance. These will only be established at the request of the guarantor. All payment plans must follow documented guidelines (see Financial Assistance policy). As new services are rendered, it is the guarantor's responsibility to contact LRGHealthcare to add additional balances to the payment plan.

Requests to extend a payment plan beyond policy guidelines up to six months may be approved by the Customer Service Manager. Requests to extend a payment plan beyond the determined policy require a financial assistance application to determine why this is necessary AND the approval of the Director of ARD/HIM.

Hardship requests beyond these time frames must be reviewed and approved by the CEO and CFO.

XI. Pre-Collection Self Pay Review Process

In order to make more accurate account designations for true self pay accounts that have fully processed through the statement process, one additional review will be done prior to sending accounts to bad debt.

A. Account Assessment of all Facility Accounts

LRGHealthcare will identify accounts ready to transfer to bad debt after a minimum of a 120-day statement process. All accounts ready to process to Bad Debt will drop into a collection Queue. All accounts will be reviewed by ARD staff prior to moving to Bad Debt.

B. Credit Score/Ability to Pay Process

a. Qualifying Account

LRGHealthcare will consider an account as qualifying for reclassification to Charity Care if the electronic determination falls within our Charity Care Guidelines. (See Financial Assistance Policy)

b. Ineligible Accounts

LRGHealthcare will not reclassify for Charity Care if the electronic determination/ability to pay falls outside the Charity Care Guidelines (see Financial Assistance Policy)

C. Account Re-Assignment

a. Qualified Accounts

These accounts will be reclassified as Charity Care and the accounts adjusted accordingly.

b. Ineligible Accounts

These accounts will progress to Bad Debt and through the Collection Process.

XII. Bad Debt Processing

Any account balance that has progressed through the entire 120 day or more statement process and remains unpaid or we are unable to reclassify as Charity care shall be considered bad debt.

A. Placement with Agency(s)

All accounts that have processed through the 120-day statement process and been assessed for the account re-classification to charity, they will be transferred to bad debt and placed with our contracted collection agency(s) after review by ARD Staff.

B. Credit Reporting

After transfer to a collection agency, balances over 100 dollars will be reported to the credit bureau after the account.

XIII. Reporting

A. Abandoned Property

LRGHealthcare abides by the NH Unclaimed and Abandoned Property regulations (RSA 471-C) which is outlined as follows: In general, it requires all financial institutions, businesses and others to review their records each year to determine whether they are in possession of any funds, securities, or other property that have been unclaimed for five years (one year for wages and utility reimbursements) or longer, and to make an annual report of their findings.

Any uncashed refund checks or other property unclaimed older than five years are reviewed on an annual basis. Desktop procedures are followed and any applicable unclaimed property is reported to the State of NH accordingly.

B. Medicare Bad Debt Reporting

It should be noted that provider and non-covered services are not included for this reporting. See Medicare Bad Debt Desk Procedure.

a. Bad Debt Accounts

All accounts sent to a collection agency that have had no activity for a period twelve (12) months, are returned and deemed uncollectible on an annual basis. These accounts are also cancelled with the respective Credit Bureau. All appropriate Medicare balances are identified and reported to Finance to be included for the filing of the full Medicare Cost Report.

b. Charity Accounts

Any account that Medicare was the primary insurance on, which has had a patient out of pocket balance adjusted off to Charity is identified annually and reported to Finance for inclusion on the full Medicare Cost Report.

C. Assessment and Management of Patient/Visitor Comments

LRGHealthcare has a formal process for reporting patient financial and clinical concerns. Any concern reported is to be documented by the employee who is taking the concern on the appropriate form. They are then logged, reviewed and distributed to the appropriate personnel to address. LRGHealthcare will investigate and respond back to individual reporting the concern. All responses will be channeled through the Director of Medical Safety and Health Management.

See procedure for LRGHealthcare Confidential Management and Assessment of Concerns.