SVMC Billing and Collection Policy

I. Purpose

To ensure a uniform and consistent manner whereby collection policies and procedures of Southwestern Vermont Medical Center are applied and administered fairly and consistently.

II. Policy

Southwestern Vermont Medical Center will provide services on an inpatient or outpatient basis to all patients without discrimination due to age, race, color, gender, immigration status, sexual orientation, religious affiliation or ability to pay. The latter ability to pay recognizes that some may not be in a hospital retains the right to have the patient establish the inability to pay.

The hospital will make every effort via a pre-admissions screening procedure to obtain all necessary personal and financial data in order to complete payment arrangements prior to services or at the time of service. All inpatient admissions will have an insurance verification completed within 24 hours of admission. In those instances where pre-admission screening is not feasible, completion of financial arrangements to include assignment of benefits, collection of copays and deductibles, accumulation of personal and financial data and insurance verification will be effective as soon after services as possible.

All Inpatient and Emergency room patients admitted with no insurance will be personally given a copy of the hospitals Financial Assistance Application and Plain language summary by the hospitals Access Department. Whenever it appears that a patient would benefit by a referral to the SVMC financial counselor to assist in completing the Financial Assistance Application or Medicaid enrollment application, admitting or billing staff will initiate such referral.

III. Procedures

A. Insurance Billing
   a. For all insured patients SVMC will bill applicable third-party payers in a timely manner provided that an assignment of benefits has been signed by the patient. It is the responsibility of the patient to provide SVMC with accurate and complete information regarding insurance coverage.
   b. SVMC will not bill insurances with claims addresses outside of the United States. Patients with foreign insurance, will be expected to make payment directly to SVMC and will be given an itemized bill to submit to their insurance company in their home country.
   c. If a claim is denied or not processed by a payer, SVMC staff will follow up with the payer and patient as appropriate to facilitate resolution of the claim. If the denial is due to factors beyond the control of SVMC and has not been resolved after prudent follow-up efforts, SVMC may bill the patient for balances due.
   d. Medicare Specific Billing Practices
      i. When an acute care setting is no longer required but the patient/family requests that the patient remain in the hospital, a HIN letter will be completed, and the patient financial counselor will be notified. The letter will advise of the financial responsibility and include an agreement to meet that obligation.
      ii. Elective services are screened for medical necessity per Medicare guidelines. If a service is deemed not medically necessary and therefore not covered by Medicare, the Medicare patient will be presented with an Advanced Beneficiary Notice (ABN) to sign.

iii. All Medicare patients presenting at SVMC for services will be asked the Medicare Secondary questions per Medicare guidelines. Claims submitted to Medicare will include the appropriate occurrence and condition codes to report patient and spouse retirement dates and employment status.

iv. Provider Based billing - Provider based clinics are outpatient departments of the hospital and are billed to Medicare as outpatient hospital services. Medicare patients seen in one of our Provider Based Hospital Departments will have two separate bills. One bill will be for the physician care and one bill will be for the Hospital/Facility services. SVMC provider based clinics include: SVMC Cardiology, SVMC Dermatology, SVMC Expresscare, SVMC Gastroenterology, SVMC General Surgery, SVMC Internal Medicine, SVMC Neurology, SVMC OB/GYN, SVMC Pediatrics, SVMC Pulmonology, SVMC Rheumatology. SVMC Deerfield Valley Health Center, SVMC Northshire Medical Center, SVMC Orthopaedics, and SVMC Pownal Family Health Center.

B. Patient Billing

a. All uninsured patients will be billed directly and timely. Self pay patients will receive an itemized bill along with a financial assistance application immediately after the account is finalized and 3 statements thereafter on 30 day cycles. Appropriate collection letters will also be used in the collection process.

b. For insured patients, after claims have been processed by third party payers, SVMC will bill patients in a timely manner for their respective liability amounts as determined by their insurance benefits. Insured patients will receive 3 statements on 30 day cycles. Appropriate collection letters may be used during this time as deemed appropriate by SVMC billing staff.

c. If statements are returned to SVMC and a correct address cannot be obtained, these accounts can be transferred to a collection agency before 3 statements are generated.

d. All account balances greater than $10.00 will be transferred to a computer letter collection service if no payment, payment arrangements or financial assistance application has been received after 3 statements (90 days from initial bill). This service will consist of a series of 3 collection letters during a time period of 6 weeks. Accounts not collected during this cycle will be returned to the hospital and after review, be transferred to a collection agency for final collection efforts. Accounts not collected by a collection agency will be returned to the hospital and reviewed to be charged off to bad debt. After accounts are charged off to bad debt, Medicare accounts will then be recorded in the hospitals Medicare Bad Debt log.

e. Physician practices are billed out of a separate billing system than the hospital billing. The physician practice accounts receive 3 statements and are then placed in an internal collection worklist. The accounts are reviewed for patient payments or contact from the patient as well as Medicaid eligibility before transferring to an outside collection agency.

f. All patients may request an itemized statement for their accounts at any time.

g. If a patient disputes his/her accounts and requests documentation regarding the bill, staff members will provide the requested documentation in writing within 10 days (if possible) and will hold account for at least 30 days before referring account for collection.

h. SVMC may approve payment arrangements for patients who indicate they may have difficulty paying their balance in a single installment.

i. Scheduled monthly payments should be no less than $25.00 per month

ii. Accounts will not be consolidated unless there is a payment arrangement in place with the patient. Furthermore accounts will not be consolidated across family members or across different service years.

iii. The Director of Revenue Cycle and Patient Accounting manager have the authority to make exceptions to this policy on a case by case basis for special circumstances.

iv. SVMC is not required to accept patient initiated payment arrangements and may refer accounts to a collection agency if the patient is unwilling to make acceptable payment arrangements or has defaulted on an established payment plan.

C. Cash Application
    a. Payments
        i. Cash and mail receipts will be handled by a designated cashier located in a secured area of the hospital. Cash applications and accounting controls will be the responsibility of the finance department.
        ii. All cash and/or checks brought in directly to the Patient Accounting department will be posted to the patients account in a cash drawer. The cash drawer is balanced daily by the patient financial advisors.
        iii. All cash transactions that have electronic remittances are posted electronically into the patient accounting system by the credit and remittance technician in the patient accounting office. All postings are balanced and reconciled with the finance department.
    b. Credit Balances/Refunds
        i. Credit balances are usually the result of overpayments by third party carriers, a combination of patient and third party payments, two or more insurance payments or incorrect postings to patients' accounts.
        ii. Resolving credit balances is the responsibility of the patient accounting staff. Credit balance reports are run daily and are to be reviewed by the patient financial advisors on a weekly basis. Every attempt must be made to determine the reason for the credit balance including a review of insurance relative to coordination of benefits. When the reason for the credit balance is determined, the proper adjustment or refund will be expedited. All patient refunds will be issued by the patient financial advisor using the computer system. All patient credit balances will first be applied to any open accounts or unpaid collection accounts before the patient is refunded any monies.
D. Adjustments
    a. Adjustments greater than $10.00 must have the approval of either the Supervisor of Patient Accounting, Revenue Cycle Director or the Vice President of Finance.
        i. Exceptions not requiring manager approval for adjustments less than $500:
            1. Contractual Allowance with third parties where claim was processed at the contracted rate. This applies to contractual adjustments only, denials MUST have the approval of management.
            2. Financial Assistance adjustments
            3. Medicare lab medical necessity adjustments, per SSI electronic claims error report.
        ii. Balances less than $2.99 will be written off to a small balance adjustment
        iii. Patient balances less than $10.00 are not sent to collection and will be written off after the third statement.
        iv. Medicaid copays are adjusted to Free Care as Medicaid eligible patients qualify for presumptive free care per the SVMC Financial Assistance program policy.
    b. Bad Debt Charge Offs
        i. All account balances that are returned from the collection agency after 180 days and deemed uncollectable will be adjusted to bad debt.
        ii. Adjustment Batch will be prepared by the collection coordinator and approved by Director of Revenue Cycle or Supervisor of Patient Accounting.
E. Collection Practices
    a. In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Billing and Collection Policy, SVMC may engage in collection activities- including extraordinary collection actions (ECAs) – to collect outstanding patient balances.
        i. General collection activities may include:
            1. Follow-up calls on statements

2. Collection letters
3. Transfer of accounts to collection agency
4. Reporting of debt to credit bureau
5. Liens may be placed on any patient account over $500 that occurred as a result of an automobile accident where payment is delayed due to third-party liability or litigation.

ii. Patient balances may be referred to a third party for collection at the discretion of SVMC. SVMC will maintain ownership of any debt referred to a debt collection agency, and accounts will be referred only under the following conditions:
1. There is a reasonable basis to believe the patient owes the debt.
2. All third party payers have been properly billed, and the remaining debt is the financial responsibility of the patient.
3. SVMC will not refer accounts for collection while a claim is pending payer payment. However, SVMC may classify certain claims as denied if such claims are in "pending" status for an unreasonable length of time despite efforts to facilitate resolution.
4. SVMC will not refer accounts for collection where the claim was denied due to an error by SVMC.
5. SVMC will not refer accounts for collection where the patient has initially applied for financial assistance and SVMC has not yet notified the patient of its determination (provided that the patient has complied with the timeline and information requests given to them by SVMC).

b. Reasonable Efforts and Extraordinary Collection Actions (ECAs)
i. Before engaging in ECAs to obtain payment for care, SVMC (in compliance with 501(r) regulations) will make certain reasonable efforts to determine whether a patient is eligible for financial assistance under our financial assistance policy.
1. ECAs will begin only when 120 days have passed since the first post discharge bill was provided.
2. At least 30 days before initiating ECAs to obtain payment, SVMC will do the following:
a. Provide the individual with written notice that indicates the availability of financial assistance, list potential ECAs that may be taken to obtain payment for care and give a deadline after which ECAs may be initiated. ECAs may be initiated after 120 days have passed since the first post-discharge bill and 30 days after the written notice. Financial assistance application will be accepted up to 240 days after the first post-discharge billing statement.
b. Provide a plain language summary along with the notice described above.
3. If ECAs have been initiated and a financial assistance application is received within the 240 days from the 1st post-discharge bill, ECAs will be suspended until determination of Financial Assistance Program eligibility is complete. If application is approved any ECAs taken on FAP eligible accounts will be reversed.

ii. After making reasonable efforts to determine financial assistance eligibility as outlined above, SVMC (or its authorized business partners) may take any of the following ECAs to obtain payment for care:
1. Reporting adverse information to credit reporting agencies/bureaus.
2. Place a lien on admissions that occur as a result of an automobile accident.

iii. SVMCs Patient accounting office is ultimately responsible for determining whether SVMC and its business partners have made reasonable efforts to determine whether an individual is eligible for financial assistance. The Director or Revenue Cycle, Supervisor of Patient Accounts or their designee has final authority to for deciding whether the organization may proceed with any of the ECAs outlined in this policy.

F. Financial Assistance
    a. All billed patients have the opportunity to contact SVMC regarding financial assistance, payment plan options and other applicable programs.
        i. SVMCs financial assistance policy and applications is available free of charge. Patients can obtain a copy:
            1. In person at any registration desk of the hospital, at any SVMC physicial practice or at the SVMC billing office.
            2. By calling the SVMC Billing office at 802-447-4500 or the financial counselor at 802-440-4083.
            3. Online at: http://svhealthcare.org/patients-visitors/billing-insurance/
        ii. Individuals with questions regarding SVMCs financial assistance policy may contact the SVMC billing office at 802-447-4500 or 802-447-4502 or SVMCs financial counselor at 802-440-4083. Or in person at 100 Hospital Drive, Bennington, VT 05201 (1st Floor, East Wing).

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