CREDIT & COLLECTION POLICY

ST. JOHN RIVERSIDE HOSPITAL
ANDRUS, Dobbs Ferry & PARK CARE PAVILION **REVISED: 1/2020, 4/2020, 3/05/21,3/22, 01/23,3/2024**

Policy. **It is the policy of St. John's Riverside Hospital to refer all self-pay accounts to external agencies for further collection efforts after following our self-pay collection process without balance resolution, financial assistance determination or presumptive charity care determination.**

Objective: **This policy addresses collection activities for both uninsured and insured patients, including copayments, co-insurance, and deductibles, for pre-service, time of service and post-service collection efforts. St. Johns Riverside Hospital is committed to informing patients regarding their financial responsibilities and available financial assistance options. All patients will be treated with dignity, respect, and compassion during our collection process.**

Purpose: **To ensure all self-pay balances from our insured, uninsured and underinsured patients have been followed appropriately and resolved prior to them becoming delinquent and assigning the account to an external agency for further collection efforts. We will make all reasonable efforts to identify and assist patients in need of financial assistance. We offer payment plans and charity care for those who qualify. Please refer to our financial assistance policy for further information concerning accessible options.**

PROCEDURE: Steps I to III outline the statement process prior to being considered for external follow-up.

I. SELF-PAY INPATIENT & OUTPATIENT ACCOUNTS: These are automatically billed utilizing the Meditech statement system as follows:

(A) Final bill is processed 2 to 4 days after date of service or discharge.

(B) 1st Statement - 5 days after final bill.

(C) 2nd Statement - 28 days after 1st Statement.

(D) 3rd Statement - 21 days after 2nd Statement.

(E) 4TH Statement – 21 days after 3rd Statement

(F) 15 days after 4th statement a Pre-Collection letter is sent to the patient. 30 days after the Pre-Collection letter and the account is approximately 120 days old, the account will be referred to an external collection agency.

II. **<u>INPATIENT AND OUTPATIENT INSURED ACCOUNTS:</u> with remaining patient responsibility:**

(A) Final Bill (Insurance Claim) 2 to 4 days after service/discharge date.

(B) 1st Statement - 5 days after all insurance companies have successfully processed claims.

(C) 2nd Statement –28 days after 1st Statement.

(D) 3rd Statement - 21 days after 2nd Statement.

(E) 4th Statement - 21 days after 3rd Statement.

(F) 15 days after 4th statement a Pre-Collection letter is sent to the patient. 30 days after the Pre-Collection letter and the account is approximately 120 days old, the account will be referred to an external collection agency.

(G) Medicare accounts are recorded on the Bad Debt Log reporting purpose.

(H) Medicare: After the generation of three statements or more (including a Pre-Collection letter) and at least 120 days after the first statement is generated, the account is transferred to bad debt.

III. **<u>The following criteria are used for deductible and co-insurance amounts applicable to the Medicare Program</u>:**

(A) <u>INPATIENT AND OUTPATIENT ACCOUNTS</u>

1. Medicare accounts are recorded on the Bad Debt Log.

2. Medicare accounts do not go through legal proceedings, agency collection only.

3. All Medicare Bad Debts are recorded and kept in a separate log and turned over the Accounting Department at year end.

4. See section II-G-H for the Medicare Bad Debt criteria.

Following the initial 120 days, accounts may be referral to an external agency. The accounts which have not been assessed for Financial Assistance have an additional 120 to apply for assistance. Collection agencies affiliated with the hospital must follow the same guidelines as outlined in the hospital's Financial Assistance Policy. Collection agencies must allow patients the time frame to apply for the financial assistance that have been placed with them.

PAYMENT ARRANGEMENT PLAN CRITERIA: Prior to placing a patient in an external agency they may be placed on a payment arrangement plan if the monthly amount agree with our guidelines which are as follows:

BALANCE DUE	NUMBER OF MONTHS TO PAY
LESS THAN $100	1 – 3
$100.00 TO $300.00	3 – 4
$300.00 TO $500.00	4 - 6
$500.00 TO $800.00	6 – 8
$800.00 TO $1,500.00	8 – 12
$1,500.00 TO $2,500.00	12 – 16
$2,500.00 TO $4,000.00	16 - 20
GREATER THAN $4,000.00	20 - 24

The primary collection agency operates under the following general guidelines:

1. **Telephone written contact continue with the patient**
2. **Account remains with the primary agency for six months.**
3. **All correspondence, written and verbal communication is documented in the agency system. Notes are provided to the hospital upon request.**
4. **After the six-month period, if payment has not been obtained, or arrangements made to resolve patient balance, the account is returned to the hospital for adjustment or further collection activity.**

Any account with a remaining balance may be referred to our secondary collection agency for continued collection efforts which may include letters, incoming/outgoing calls. The secondary agency will follow the same procedure as the primary agency.

New York State Restricts Property Liens and Money Judgments for Medical Debt

New York Governor Kathy Hochul recently signed into law A.7363-A/S.8903-A, which amends Civil Practice Law and Rules to prohibit Article 28 hospitals and health care providers authorized under Article 8 of the Education Law from placing property liens against a debtor's primary residence. It also prohibits such providers from garnishing wages in medical debt judgements.

The Governor signed the bill on November 23, 2022, with an immediate effective date. Members with questions on the implementation of these changes on their collection practices should seek the advice of legal counsel.

ADDENDUM

1. Inpatient and outpatient partial payment accounts are placed on the Contract Payment System.
2. Self-pay accounts have been outsourced to a collection agency, to make necessary phone calls and other arrangements as required.
3. If the patient/guarantor gives notification in writing that he/she has no intention of paying the balance of the accounts, this account will be given to an external collection agency despite the age of the account or the aforementioned criteria. This will be documented in the patient's account. The only exception is Medicare accounts that will be held 120 days.
4. If return mail is received or conditions present where the patient cannot be contacted, either via telephone or mail, the account will be turned over to an external collection agency despite the age of the account or the aforementioned criteria. It is necessary to document the patient's account. Exception is Medicare Accounts that will be held 120 days.
5. Behavioral Health Services patients may have their fees waived upon approval by the BHS Administrative Staff, based on their determination of medical necessity.
6. Medicaid co-pays will be written off after receiving three statements.
7. All eligible accounts are referred to external collection after the 120-day cycle is completed with exceptions.
8. Agencies are given approximately six months to resolve collection efforts. If there is no resolution by the end of six months, the accounts will be returned to the hospital as closed accounts.
9. Uninsured Patients: A discounted cash price is available for patients who are not eligible for our charity care program, Health Solutions. Please refer to our Financial and Charity Care Program policy.