ROPER ST. FRANCIS

Policy & Procedure

Policy #:	
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Administrative Approval: (Type Name)	Bret Johnson
Administrative Title:	
Originator (Title):	Diane Story, Director Revenue Cycle Improvement

Hospital: All RSFH Hospitals

Division: Patient Financial Services

Subject: **Billing and Collections Policy**

OBJECTIVE

Roper St Francis seeks to allocate available financial resources effectively to reduce the cost of health care services for those patients within the community, who are most in need, consistent with their respective legal obligations. This policy recognizes the financial resources of Roper St Francis are limited; and that Roper St Francis has a fiduciary responsibility to bill and collect appropriately for patient services. Roper St Francis does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual preference, age, or disability in their policies, or in the application of their policies, including the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, eligibility status determinations, or in their billing and collection practices.

Roper St Francis recognizes the cost of necessary health care services can impose a financial burden on patients who are uninsured or underinsured and has acted to lessen that burden for patients. Roper St Francis also recognizes the billing and collection process is complex and has implemented procedures to make the process more understandable for patients; and to inform patients about discount and financial assistance options.

Consistent with our patient commitment, Roper St Francis maintains a billing and collection policy that complies with applicable state and federal laws and regulations. The policy addresses only those programs and processes applicable to patients (and patient guarantors) and not third party payers. The policy is developed to ensure compliance with applicable regulations required under (1) the Centers for Medicare & Medicaid Services Medicare Bad Debt Requirements (42 CFR § 413.89), (2) the Medicare Provider Reimbursement Manual (Part I, Chapter 3), and (3) the Internal Revenue Code Section 501(r).

■ DEFINITIONS

Financial Assistance Program. A program that is intended to assist low-income patients who do not otherwise have the ability to pay for their health care services. Such assistance should take into account each individual's ability to contribute to the cost of his or her care. Consideration is also given to patients who have exhausted their insurance benefits and/or who exceed financial eligibility criteria but face extraordinary medical costs. A financial assistance program is not a substitute for employer-sponsored, public financial assistance, or individually purchased insurance programs.

Medically Necessary Service: A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act.

Elective: Those services that, in the opinion of a physician, are not medically necessary or can be safely postponed.

Emergency Care: Immediate care which is necessary in the opinion of a physician to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any organs or body parts.

Non-Covered Services: Non-medical services, such as social, educational, and vocational services; cosmetic surgery; self- administered medications.

Primary Care: Primary care consists of health care services customarily provided by general practitioners, family practitioners, general internists, general pediatricians, and primary care nurse practitioners or physician assistants, for purposes of prevention, diagnosis, or treatment of acute or chronic disease or injury, but excludes ancillary services and maternity care services.

Prompt Pay Discount: A discount provided on a patient's out-of-pocket expenses when such expenses are paid within a pre-determined number of days from the date of service or initial statement.

Estimate of Patient Liability: An expected out-of-pocket dollar amount provided to the patient based on the patient's specific procedure, attending physician and insurance plan. An estimate should not be interpreted as an exact or final cost.

Bad Debt: Accounts that have been determined to be uncollectible because the patient has been unwilling to pay for their medical care.

Household Financial Income: Household Financial Income as measured against annual Federal Poverty Guidelines includes, but is not limited to the following:
Annual household pre-tax job earnings
Unemployment compensation
Workers' Compensation
Social Security and Supplemental Security Income
Veteran's payments
Pension or retirement income

Other applicable income to include, but not limited to, rents, alimony, child support, and any other miscellaneous source.

Third Party Insurers: Any party insuring payment on behalf of a patient to include but not limited to: insurance companies, Workers' Compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, etc., or third-party liability resulting from automobile or other accidents.

Uninsured: Patients who are not covered under an insurance health plan, Workers' Compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, etc., or third-party liability resulting from automobile or other accidents.

Underinsured: Patients covered by a source of third party funding, but at risk of high out-of-pocket expenditures due to their plan benefits package. This may include, but is not limited to, high deductible plans, high coinsurance/copay plans, low per diem policies, etc.

■ CODE OF CONDUCT

Roper St Francis must adhere to a specific code of conduct with respect to patient billing and collection activities. Any agents, including collection agencies, engaged by the providers to assist with collections are expected to adhere to the same guidelines. These guidelines affirm the providers' commitment to treating patients with fairness and respect. The guidelines are as follows:

- Maintain a high standard of fairness, honesty, and courtesy in the conduct of business and avoid any activity which may bring reproach to Roper St Francis;
- Inform patients of available options for payment or settlement of outstanding charges;
- Apply billing and collection practices uniformly to all patients and do not discriminate on the basis of race, color, national origin, citizenship, religion, creed, sex, sexual preference, age, or disability;
- Show understanding and offer due consideration for patients' financial problems and assist patients with payment obligations according to the merits of each case individually;
- Make every effort to negotiate reasonable arrangements with patients who request to settle outstanding debts through partial payment;
- Comply with all state and federal laws governing the collection of debt including, but not limited to, the United States Fair Debt Collection Practices Act;
- Ensure the confidentiality of patient information is appropriately protected and that Roper St Francis agents and contractors adhere to contractual obligations concerning confidentiality (including any HIPAA Business Associate Agreement);
- Do not add interest to Roper St Francis accounts (nor threaten to do so);
- Do not seek to garnish wages of a patient or guarantor (nor threaten to do so);

- Do not place liens on the personal property (which does not include real estate) or motor vehicle of a patient (nor threaten to do so);

- Do not place liens on any real estate owned by a patient (including the personal residence of the patient) without the approval of the applicable Board of Trustees based on consideration of such factors as the market value of the real estate, the patient's income, assets of the patient (nor threaten to do so);

- Do not seek legal execution against the personal residence or motor vehicle of the patient or guarantor without the express approval of the Board of Trustees of Roper St Francis which approvals by the Board will be made on an individual basis;

- Do not foreclose on any property of a patient (or otherwise seek legal execution against real property) without the approval of the Board of Trustees of Roper St Francis (nor threaten to do so); and

- Ensure all agents, contractors or subcontractors are aware of, and agree to abide by, these guidelines.

■ DELIVERY OF HEALTH CARE SERVICES

Roper St Francis evaluates the delivery of health care services for all patients who present for services in the Emergency Department regardless of their ability to pay. The urgency of treatment associated with each patient's presenting clinical symptoms will be determined by a medical professional in accordance with local standards of practice, national and state clinical standards of care, and the hospital medical staff policies and procedures. It is important to note that classification of patients' medical condition is for clinical management purposes only, and such classifications are intended for addressing the order in which physicians should see patients based on their presenting clinical symptoms. These classifications do not reflect medical evaluation of the patient's medical condition reflected in final diagnosis. Roper St Francis also complies with the federal Emergency Medical Treatment and Active Labor Act (EMTALA) by conducting a medical screening examination to determine whether an emergency medical condition exists when required by that law.

Clinical and financial considerations as well as the benefits offered by private insurance or government programs may affect the timing of, or access to, non-emergent or non-urgent health care services (i.e., elective services). Such services may be delayed or deferred based on consultation with the hospital's clinical staff and, if necessary, and if so available, the patient's healthcare provider. Roper St Francis may decline to provide a patient with non-emergent, non- urgent services in those cases when a payment source cannot be identified.

For patients covered by private insurance or government programs, patient choices related to the delivery of, and access to, care are often defined in the insurance plan's or the government program's coverage guidelines.

For patients who are uninsured or underinsured, Roper St Francis will work with patients to find a Financial Assistance Program that may cover some or all of their unpaid hospital bill(s). For those patients with private insurance, Roper St Francis must work through the patient and the insurer to identify what services may be covered by the patient's insurance policy. For patients seeking non-emergent and non-urgent services, it is the patient's responsibility to know what services will be covered prior to seeking care.

A. Emergency and Urgent Care Services

Any patient who comes to Roper St Francis will be evaluated as to the level of emergency or urgent care services without regard to the patient's identification, insurance coverage, or ability to pay.

1. Emergency Level Services include:
Medically Necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity including severe pain, that the absence of prompt medical attention could reasonably be expected by a *prudent layperson who possesses an average knowledge of health and medicine* to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e) (1) (B) of the Social Security Act, 42 U.S.C. § 1295dd (e) (l) (B). A medical screening examination and any subsequent treatment for an existing emergency medical condition or any other such service rendered to the extent required pursuant to the federal EMTALA (42 USC 1395(dd) qualifies as an Emergency Level Service.

2. Urgent Care Services include:
Medically Necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a *prudent layperson would believe that the absence of medical attention within 24 hours* could reasonably expect to result in: placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent Care Services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health, but prompt medical services are needed.

3. EMTALA Level Requirements:
In accordance with federal requirements, EMTALA is triggered for anyone who comes to the hospital property requesting examination or treatment of an emergency level service (emergency medical condition), or who enters the emergency department requesting examination or treatment for a medical condition. Most commonly, unscheduled persons present themselves at the emergency department. However, unscheduled persons requesting services for an emergency medical condition while presenting at another inpatient unit, clinic, or other ancillary area may also be subject to an emergency medical screening examination in accordance with EMTALA. Examination and treatment for emergency medical conditions or any such other service rendered to the extent required under EMTALA, will be provided to the patient and will qualify as emergency care. The determination that there is an emergency medical condition is made by the examining physician or other qualified medical personnel of the hospital as documented in the medical record. The determination that there is an urgent or primary medical condition is also made by the examining physician or other qualified medical personnel of the hospital as documented in the medical record.

B. Non-Emergent, Non-Urgent Services:

For patients who either (1) arrive to Roper St Francis seeking non-emergent or non-urgent level care or (2) seek additional care following stabilization of an emergency medical condition, Roper St Francis may provide elective services after consulting with Roper St Francis clinical staff and

reviewing the patient's coverage options. Elective Services can be Medically Necessary services that do not meet the definition of Emergency Level services or Urgent Care Services above. Typically, these services are either primary care services or medical procedures scheduled in advance by the patient or by the health care provider (hospital, physician office, other).

■ COLLECTION OF INFORMATION ON PATIENT COVERAGE AND FINANCIAL RESOURCES

A. Patient Obligations:

Prior to the delivery of any health care services (except for cases requiring Emergency Level Services or Urgent Care services), the patient is expected to provide timely and accurate information on their insurance status, demographic information, changes to their family income or insurance status, and information on any deductibles or co-payments that are owed based on their existing insurance or financial program's payment obligations. The detailed information may include:

1. Full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, citizenship, residency information, and the patient's applicable financial resources that may be used to pay their bill;

2. Full name of the patient's guarantor, their address, telephone number, date of birth, social security number (if available), current health insurance coverage options, and their applicable financial resources that may be used to pay for the patient's bill; and

Other resources that may be used to pay their bill, including other insurance programs, motor vehicle or homeowners insurance policies if the treatment was due to an accident, worker's compensation programs, and student insurance policies, among others.

It is ultimately the patient's obligation to keep track of and timely pay their unpaid hospital bill, including any existing co-payments and deductibles. The patient is further required to inform either his/her current health insurer (if insured) or the government agency that determined the patient's eligibility status in a government program (if participating) of any changes in family income or insurance status.

B. Hospital Obligations:

Roper St Francis will make all reasonable and diligent efforts to collect the patient's insurance and other information to verify coverage for the health care services to be provided by Roper St Francis. These efforts may occur during scheduling or pre-registration, while the patient is admitted in the hospital, upon discharge, or during the collection process which may occur for a reasonable time following discharge from Roper St Francis. This information will be obtained prior to the delivery of any non-emergent and non-urgent health care services (i.e., elective procedures as defined in this Billing and Collection P olicy). Roper St Francis will delay any attempt to obtain this information during the delivery of any EMTALA level emergency or urgent care services, if the process to obtain this information will delay or interfere with either the medical screening examination or the services undertaken to stabilize an emergency medical condition.

If the patient or guarantor/guardian is unable to provide the information needed, and the patient consents, Roper St Francis will make reasonable efforts to contact relatives, friends, guarantor/guardian, and the third party for additional information.

Roper St Francis maintains all information in accordance with applicable federal and state privacy and security laws.

FINANCIAL ASSISTANCE PROGRAMS

Roper St Francis patients may be eligible for free or reduced cost of health care services through various State Programs, or the Hospital Financial Assistance Program based on the patient's financial circumstances.

Refer to PFS Financial Assistance Policy for more detail. A copy of the Financial Assistance Policy can be obtained at any registration desk.

POLICY

Roper St Francis generally expects patients or their third party payers to pay in full for services provided. Roper St Francis will bill third party payers in accordance with the requirements of applicable law, contracts with third party payers or applicable billing guidelines. Patients are also responsible for charges that are not paid by a third party payer within a reasonable time frame or for any balances that exist after payment by the third party payer. Patients who seek services (other than emergency services) may be requested to pay in advance for services that will not be covered by third party payers, including co- payments and deductibles related to covered services. The patient's failure to pay or make satisfactory financial arrangements will render the account delinquent. The hospital reserves the right to take collection actions as permitted by law concerning balances due from either the patient or third party insurers.

Pre Service

Roper St Francis is committed to helping patients understand and manage the cost of services they receive before those services are delivered. To help patients prepare for and manage the cost of care they receive, a registration team member may perform pre-service review steps to ensure all information collected is accurate. Accurate information is critical to avoid billing issues and to ensure insurance benefits can be accessed to minimize out-of-pocket expenses.

Before non-emergency services are delivered or **after** emergency conditions have been stabilized, the registration team may perform the following activities:

- Validate and Protect Patient Identity – to protect medical and financial information, Roper St Francis may use commercially available data sources to validate the accuracy of names and addresses. To receive non-emergency services, Roper St Francis may ask the patient or guarantor for photo ID and may include a copy of your photo ID with your medical record.
- Verify Insurance Benefits – based on information provided by patients and guarantors, Roper St Francis may use our data systems to communicate with insurance companies to verify eligibility and benefits. If insurance information is not provided, Roper St Francis may check with the major insurance companies and applicable state Medicaid program to check for coverage.
- Verify Medical Necessity – not all services are covered by insurance policies. To minimize cost associated with services not covered by insurance Roper St Francis may verify the appropriateness of per-service diagnosis and procedure codes so that patients can make an informed decisions about receiving the recommended services.
- Obtain Prior Authorizations – If the services to be provided require prior authorization from an insurance company, Roper St Francis will attempt to secure that authorization from your insurance

company. Each patient is responsible for making sure his/her insurance benefits will cover the cost of services to be provided. If Roper St Francis is unable to obtain proper authorization, patients may be responsible for the cost of services delivered.

- Identify Open Bad Debt Accounts – if the patient or guarantor has previously unpaid accounts that have not been enrolled in a payment plan, those balances may be required to be paid in full or paid in part and enrolled in our payment plan.
- Produce an Estimate of Patient Liability – to help patients make informed health care purchasing decisions, an estimate of service costs and patient liabilities may be provided. Roper St Francis will use all data described in this section to estimate out-of-pocket expenses based on specific insurance benefits, prior authorization requirements and any open prior accounts.
- In the event that our registration team is unable to identify coverage for services to be provided, patients may be referred to a financial counselor.
- Patients will be requested to pay all or a portion of the estimated co-pays, co-insurance amounts and/or deductible amounts. If the patient is uninsured, a percentage of gross charges will be requested.
- Our pre-service financial clearance process is designed to help patient's manage unexpected costs associated with health care services. Roper St Francis also provides payment options to help patients manage balances within their budgets.

Financial Assistance Programs

Roper St Francis patients may be eligible for free or reduced cost of health care services through various State Programs, or the Hospital Financial Assistance Program based on the patient's financial circumstances.

Refer to PFS Financial Assistance Policy for more detail. A copy of the Financial Assistance Policy can be obtained at any registration desk.

Patients are advised that physician services (whether or not provided in a hospital setting) are generally not subject to the Hospital Financial Assistance Program. Physicians or physician groups may have their own policies for offering discounts or providing free care. Roper St Francis encourages patients to discuss the availability of discounts or free care directly with their physicians or with a billing representative.

Medical Indigency

This program is designed to assist South Carolina residents who have had a catastrophic medical event regardless of their insurance coverage that has resulted in very large hospital bills in comparison to their financial resources. Patients who have incurred balance after all insurance or third- party payments that is greater than 20% of their total household financial resources may be eligible for a Hardship Settlement discount. Patients seeking a hardship settlement should inquire about this program by calling the customer service department after receiving their first balance due statement.

■ BILLING AND COLLECTION PROCESS

A. General

Roper St Francis uses the same reasonable efforts and follows the same reasonable process for collecting amounts due for services provided to all patients, including insured, underinsured or uninsured patients. Collection activities may occur during the pre-registration process and will continue until account resolution, a determination the account is uncollectible, or determination of eligibility for financial assistance. The collection process may include the use of deposits, the implementation of payment plans or discretionary settlements. The collection process may involve the use of outside collection agencies. The

collection process is documented in the patient's account files accessible to the hospital and its business associates involved in the collections process. (Collection will not, however, be pursued against patients who fall within populations exempt from collection action by law.)

Roper St Francis will make reasonable and diligent efforts to investigate whether a third party resource may be responsible for the services provided by the hospital, including but not limited to: (1) a motor vehicle or home owner's liability policy, (2) general accident or personal injury protection policies, (3) worker's compensation programs, (4) student insurance policies. In accordance with applicable state regulations or the insurance contract, for any claim where reasonable and diligent efforts resulted in a recovery on the health care claim billed to a private insurer or public program, Roper St Francis will report the recovery and offset it against the claim paid by the private insurer or public program. If Roper St Francis has prior knowledge and is legally able, it will attempt to secure assignment on a patient's right to third party coverage (or settlement) on services provided due to an accident. Refer to Roper St Francis overpayment and or refund/credit balance policy.

B. Collection Notices

Roper St Francis has a fiduciary duty to seek payment for services it has provided from patients who are deemed able to pay. Roper St Francis reserves the right to utilize outside vendors to assist the facility and patients regarding balances due, process payment plans, etc. When a balance is owed by the patient, the payment is considered "Self-Pay" and payment in full is expected.

- An account is determined to be Self-Pay if:
  - There is no insurance on record.
  - All expected payments from the insurance carriers, Medicare and other third party payers have been paid.
  - A patient has not responded timely to requests for information/documentation needed to determine eligibility under Financial Assistance Policies.
  - Patient does not provide information requested from third party insurers to process claims
- All self-pay accounts process through specific statement cycles.
- Because of the inherent delays and other issues with Medicaid eligibility processes, Roper St Francis may perform Medicaid eligibility checks on all Self-Pay accounts after discharge. If Medicaid coverage is identified, the account will be reclassified to Medicaid from Self-Pay and billed to Medicaid.
- All Self-Pay accounts will be sent a minimum of three statements with the last or next to the last contact notifying the patient that if the bill remains unpaid, in 30 days they will be referred for additional collection actions.
- On any Self-Pay statement, notification is present that an itemized bill can be requested by contacting our Customer Service call center.
- This process may be supplemented by other notification methods that constitute a genuine effort to contact the party responsible for the obligation, including, for example, telephone calls, collection letters, personal contact notices, and computer notifications.
- For statements that have been returned as undeliverable, reasonable efforts will be made to determine an accurate mailing address using internal and external tools and resources. These efforts will be documented on each patient account. Refer to the Returned Mail Processing policy.

C. **Documentation of Collection Effort**

Patient financial records will be maintained by Roper St Francis as required by applicable law and in accordance with Roper St Francis policies.

Documentation will support billing and collection action undertaken on a regular, frequent basis. The patient's file will include all documentation of the hospital's collection effort including the bills, codes and letter templates, reports of telephone and personal contact, and any other efforts made. Such documentation is maintained until audit review by a federal and/or state agency of the fiscal year cost report in which the bill or account is reported or longer if required by law or internal policy.

D. Populations Exempt from Collection Activities

Patients who are enrolled in a public health insurance program including but not limited to State Medicaid Plans are exempt from billing or collection action after the initial bill pursuant to state regulations subject to the following exceptions:

a) Roper St Francis may seek collection action against any patient enrolled in the above mentioned programs for their required co-payments and deductibles that are set forth by each specific program.

b) Roper St Francis may initiate billing or collection for a patient who alleges that he or she is a participant in a State Program that covers the costs of the services, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in a State Program, (including receipt or verification of signed application), Roper St Francis shall cease their billing or collection activities.

c) Roper St Francis may seek collection action for non-covered services.

Under the Hospital Financial Assistance Program, Roper St Francis will cease any collection or billing actions against a patient who is unable to pay a bill at any time during the billing process. If patient/guarantor is eligible for Financial Assistance, Roper St Francis will keep any and all documentation that shows that the patient met the Hospital Financial Assistance Program. If documentation is missing or incomplete, patients are given a reasonable timeframe of 30-45 days to submit the requirement documentation. It not received in a reasonable timeframe, billing and collection actions will commence.

Roper St Francis and their agents shall not continue collection or billing on a patient who a member of a bankruptcy is proceeding except to secure its rights as a creditor in the appropriate order.

E. Deposits and Payment Plans

1. Patients or their responsible parties are expected to pay their full liability for services rendered within thirty (30) days of receipt of their first bill or in accordance with a mutually agreed upon installment payment plan

2. Roper St Francis may request a deposit from patients eligible for Financial Hardship based on eligibility level.

3. In an effort to provide the guarantor and the health system an opportunity to resolve accounts in a favorable and effective manner, the following payment arrangements are available to those who have indicated they cannot pay in full. Once a payment plan has been established, guarantors are sent monthly statements until the account is paid in full. The following actions are taken if the guarantor fails to pay as promised:
    - First missed payment – reminder notice/broken promise letter is sent to the guarantor.

- Second **and** consecutive missed payment – the payment plan arrangement is voided and the account is pre-listed to a collection agency.

All payment amounts will be accepted, however, a long term payment arrangement must be established to prevent the account from being referred to a collection agency.

MINIMUM MONTHLY PAYMENT GUIDELINES		
Account Balance	**Minimum Monthly Payment**	**Maximum Time**
$0 to 100	$25.00	4 months
$101 – 500	$50.00	10 months
$501 – 1,500	$100.00	15 months
$1,501 – 3,000	$150.00	20 months
$3,001 - 6,000	$250.00	24 months
$6,001 – 10,000	$375.00	27 months
$10,001 - 15,000	$500.00	30 months
$15,001 and up	Divide balance by 30 months	30 months

4. **Prompt Pay Discounts**. Roper St Francis may offer limited prompt pay discounts (which are intended to reduce collection expenses for Roper St Francis) to patients who pay outstanding balances within a predefined period of time. All patients with account balances in excess of $0.00 are eligible to receive a prompt pay discount of 10% of the balance for claims paid in full immediately upon request. Patients must request the discount. The discount cannot be combined with the Hospital Financial Assistance Program.

F. Discretionary Settlements

Roper St Francis may choose to settle outstanding accounts based upon extenuating circumstances.

G. Outside Collection Agencies

Roper St Francis contracts with outside collection agencies to assist in the collection of certain accounts, including patient responsibility amounts not resolved after issuance of hospital bills or final notices. Roper St Francis may assign, however, such debt as bad debt or charity care (otherwise deemed as uncollectible) prior to 120 days if Roper St Francis is able to determine that the patient was unable to pay under the Hospital Financial Assistance Program.

Roper St. Francis has a specific authorization or contract with the outside collection agencies and requires such agencies to abide by the Roper St Francis credit and collection policies for those debts that the agency is pursuing. All outside collection agencies hired by Roper St Francis will provide the patient with an opportunity to file a grievance and will forward to the hospital the results of such patient grievances. Roper St Francis requires any outside collection agency that they contract with to be licensed with the State of South Carolina Regulations. Additionally, contracted collection agencies must abide by the requirements of the Federal Fair Debt Collection Practices Act.

Bad Debt Pre-Placement Review

After the initial three contacts and after a period of no less than 120 days from discharge Self-Pay accounts are pre-listed for movement to bad debt. The following actions, if applicable, are then taken:

- Accounts are removed if any information has been obtained subsequent to being pre-listed that would indicate the account is collectible.

Primary Bad Debt Placement

Primary Bad Debt placement is a process that usually occurs approximately one week after the accounts reach the pre-list status.

- Accounts are submitted to a hospital approved primary collection agency. Accounts remain with the primary collection agency for a period of at least 270 days
- The primary collection agency will notify all patients they contact for the purpose of debt collection of Roper St Francis' Financial Assistance policy.
- If, after 270 days, the primary collection agency is unsuccessful in collecting the full balance, establishing a monthly payment plan, or receiving a promise to pay, the account is transferred to a secondary collection agency for further and final collected attempts.

Secondary Bad Debt Placement

Secondary Bad Debt placement occurs after primary placement for all accounts over 270 days that have had no payment activity.

- The secondary agency will notify all patients they contact for the purpose of debt collection of Roper St Francis' Financial Assistance policy.
- Unpaid accounts stay with the secondary agency until they meet the balance and age criteria as defined in the table below:

Balance	Return to RSFH
$1,500 and Below	150 Days from Last Payment (if no promise to pay)
$1,500.01 and Above	365 Days from Last Payment (if no promise to pay)

Bad Debt Account Recall

Roper St Francis will recall accounts from primary and secondary agencies and clear the patients file with both the agencies and credit bureaus, if applicable, for the following reasons:

- Patient files for bankruptcy (see Bankruptcy Policy and Procedure)
- Filing of an estate for the patient (see Probate Policy and Procedure)
- Error by Roper St Francis that caused the account to improperly be pre-listed (i.e., payment posting error)
- A deliverable phone number and address cannot be identified for the patient
- Other as deemed necessary by Administration.

In the pursuit of collections, Roper St. Francis, and its agents, **will not**:

- Attach liens on property,
- Garnish wages (not permitted in the state of South Carolina),
- Pursue legal action, unless it is recommended by any of the self-pay billing entities (internal, CAB, Collection Agencies) that legal action should be taken against the guarantor. This will be presented for approval to the CFO and Corporate Legal Counsel,
- Sell accounts, or
- Send bankrupt guarantors to collection agencies.