

Cochise Regional Hospital
Business Office Policies

Business Office Staff and Operations

POLICY

It is the policy of Cochise Regional Hospital that the Business Office has the appropriate number of staff for each position and working hours are clearly defined.

PROCEDURE

Current staff for the Business Office consists of the following:

See organizational chart.

Business Office hours:

Billing: 8:00 AM to 4:30 PM Monday through Friday

Admitting: 24 hours a day/7 days a week

Payments can be made any time with the Admitting Clerk.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 5/13, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

IOP Admissions and Registration

POLICY

It is the policy of Cochise Regional Hospital to maintain high standards in obtaining information during the registration process.

PROCEDURE

On a daily basis, the following registration should be monitored for quality:

- A. All inpatient and outpatient registrations.
- B. Outpatient diagnostics and all other outpatient services should be sampled according to necessity.

Noted errors should be tracked using the Admitting Error Log and reported to the Quality and Safety Committee on a monthly basis.

All errors, once noted, should be returned to the staff member for correction and examination in the form of an Admitting Error Log. Errors will be fixed within five working days.

Meetings will be held with Admitting staff members as deemed necessary by the Admitting Team Leader, Business Office Manager and/or Chief Financial Officer, to review error rates, problem solving issues, set goals, and provide education on deficiencies.

Summary findings should be forwarded to the facility's Quality Improvement Coordinator for tracking purposes.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 5/13, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Pre-Registration

POLICY

It is the policy of Cochise Regional Hospital to pre-register as many elective services as possible.

PROCEDURE

Copies of the Pre-Registration Sheets and Checklist may be left at the Main Admitting Desk for scheduled patients to complete and return to the Admitting Clerk. Otherwise, obtain copy of Departmental schedules to include:

- Elective inpatients
- Ambulatory surgeries
- MRIs
- Cat scans
- Mammography
- Physical Therapy

The departments will make contact with the patient to obtain:

- Demographic data
- Insurance information
- Discuss patient financial obligation (see Collections Department if needed)

Verify insurance (as defined in Insurance Verification Policy and Procedure/Admission Section).

Prior to patient arrival, prepare:

- Arm band
- Patient stickers
- Authorizations/Certifications

Cochise Regional Hospital
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Review with patient:

- Anticipated patient financial liabilities (see Financial Counseling Section), Collections (Collection Section), and Charity Care (Financial Counseling Section).

Inform patient of valuables policy if valuables are turned into an Admitting clerk.

Review system generated pre-registration report for cancellations and schedule changes on a daily basis. Cancel pre-registration when patient does not show for appointment.

Document all activities in system (use system comments section to document any changes).

Effective Date: 07/04

Reviewed: 11/07, 12/08, 5/13, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Registration

POLICY

It is the policy of Cochise Regional Hospital to register all patients receiving services or supplies in a timely, efficient, and professional manner.

PROCEDURE

Inpatient, Outpatient, and Surgery

Complete and/or verify all demographic information.

Complete and/or verify all insurance data.

Copy cards and driver's license.

Obtain any required insurance forms (claim forms, first report of injury, ICA forms)

Verify:

- Policy and group numbers
- HIC numbers
- Social Security number
- Medicaid number
- Plan number
- Payer address and telephone number
- Authorizations needed

Verify correct assignment of social security number and birth date.

If accident, enter appropriate occurrence codes, and date(s) of injury.

If industrial injury is indicated, contact employer to verify and obtain carrier information, employer address, phone numbers, and claim number if applicable.

Verify insurance benefits (see Verification Policy and Procedure/Admissions Section).

Copy insurance card and run eligibility for appropriate coverage. If required, contact the appropriate party for authorization.

Make payment arrangements for estimated self-pay portion (see Collections Department).

If patient was not pre-registered, prepare patient stickers and arm band.

Obtain electronic signatures, copy of insurance card and identification cards.

(See Valuables Policy). Patients should be strongly urged to leave valuables at home or in the custody of a relative.

Obtain bed assignment from nursing unit.

Inform nursing station of patient arrival.

Document all activities in system comments.

Emergency Department

Patient will be triaged by Emergency Room personnel. After patient triaged, then appropriate registration will take place.

Complete all demographic information.

Complete all insurance data.

Copy insurance cards and identification.

Obtain any required insurance forms (claim forms, first report of injury, non-availability statement, etc.)

Offer AHCCCS applications or any other available type of forms that may be relevant or useful for the patient's financial status.

Verify:

- Policy and group numbers
- HIC numbers
- Social Security number
- Medicaid number
- Plan number
- Payer address and telephone number
- verify eligibility

Verify correct assignment of social security number and birth date.

If accident, enter appropriate occurrence codes and date(s) of injury.

If industrial injury is indicated, contact employer to verify and obtain carrier information.

Copy insurance card and check for prior authorization requirements. If required, contact the appropriate party for authorization.

Prepare patient stickers and arm band.

Obtain all required electronic signatures.

Follow self pay policy. (see Collections Department)

(See Valuables Policy) Patients should be strongly urged to leave the valuables in the custody of a relative.

Patients should be routed back to Registration for discharge clearance after treatment is completed, if information is incomplete and for collection of co-payments.

Document all activities in system comments.

Outpatient

Complete all demographic information.

Complete all insurance data.

Copy cards and identification.

Obtain any required insurance forms (claim forms, first report of injury, non-availability statement, etc.)

Verify:

- Policy and group numbers
- HIC numbers
- Social Security number
- Medicaid number
- Plan number
- Payer address and telephone number
- Check eligibility

Verify correct assignment of social security number and birth date.

If accident, enter appropriate occurrence codes and date(s) of injury.

If industrial injury is indicated, contact employer to verify and obtain carrier information.

Copy insurance card and check for prior authorization requirements. If required, contact the appropriate party for authorization.

If not pre-registered, prepare arm band and patient stickers.

Obtain all required signatures.

Make payment arrangements for estimated self-pay portion. (see Collections Department)

Distribute face sheets and other forms per hospital policy.

Document all activities in system comments.

Recurring Accounts for Physical Therapy and IV Infusion/IV Therapy and IV Infusion/IV Therapy-Note: Recurring accounts will only maintain open for a total of three months as directed by Medicare guidelines.

Complete all demographic information.

Complete all insurance data.

Copy cards and identification.

Obtain any required insurance forms (claim forms, first report of injury, non-availability statement, etc.)

Verify:

- Policy and group numbers
- HIC numbers
- Social Security number
- Medicaid number
- Plan number
- Payer address and telephone number
- Eligibility For Benefits

Verify correct assignment of social security number and birth date.

If accident, enter appropriate occurrence codes and date(s) of injury.

If industrial injury is indicated, contact employer to verify and obtain carrier information.

Verify insurance benefits. (See Verification Policy and Procedure/Admissions Section)

Prepare patient stickers, if applicable.

Obtain all required electronic signatures.

Make payment arrangements for estimated self-pay portion. (See Collections Department)

Discharge from system if there has not been activity on the account for more than 30 days.

Document all activities in system comments.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 5/13, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
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Emergency Room Registration

POLICY

It is the policy of Cochise Regional Hospital for Nursing personnel to triage all patients prior to the gathering of financial data. All demographic and financial data will be obtained at the patient's bedside or after medical evaluation has been done, depending on ER volume and the patient's needs. Payment request or financial assistance requests will be obtained by the Collections Department or trained Admitting staff.

PROCEDURE

The patient will be assessed by a nurse within fifteen minutes of arrival.

Quick registration at window or bedside in order to provide efficient quality patient care.

DOB, Name chief complaints are required for quick reg.

The Admitting Clerk will provide the Emergency Department with patient stickers with the information received from the nurse.

The Admitting Clerk will follow all procedures established in the Admissions Policy and Procedure Section.

If an Emergency Department backlog exists, the Admitting Clerk will alert the patient at 15 minute intervals (i.e., Ms. Smith, we are still backlogged in the ER. Hopefully we will be able to see you soon.)

Effective Date: 07/04

Reviewed: 11/07, 5/13, 07/14

Revised: 11/07, 5/13, 07/14

Cochise Regional Hospital
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Discharge/Transfer

POLICY

It is the policy of Cochise Regional Hospital to discharge patients upon the written order of the physician and clearance received from the Business Office.

PROCEDURE

Discharge

Patients may not be discharged until Business Office has financially cleared the patient.

The Admitting Clerk or Business Office staff member will review patient information to ensure financial requirements have been met.

The discharge nurse will escort the patient to their vehicle. If the patient is not ambulatory, a representative will be sent to the patient's room to obtain any additional financial information needed.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 5/13, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Verification

POLICY

It is the policy of Cochise Regional Hospital to verify financial data and benefits for all inpatients, ambulatory surgeries, outpatient, patient observation, and selected ancillary services.

PROCEDURE

Complete insurance verification; obtain authorizations from insurances, and guidelines.

Note all workers' compensation claims must be verified with employer as well as carrier. Appropriate claim numbers must be obtained. Letter should be provided to patients claiming Workman Comp stating they need to provide insurance information within 15 days or they will be considered self-pay.

Effective Date: 07/04
Reviewed: 11/07, 12/08, 9/13, 07/14
Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Advance Directives

POLICY

It is the policy of Cochise Regional Hospital to inform all inpatients, observation patients, and outpatient surgeries of their rights regarding Advance Directives (Durable Power of Attorney for Healthcare/Living Will).

PROCEDURE

Inquire at the time of inpatient registration if the patient has completed an Advance Directive, if yes, request a copy for the facility records. Also note in the patient's electronic health record.

If the patient is unaware of the Advance Directive, furnish an information pamphlet with detailed information.

Alert nursing or social services that the patient does not have a Living Will.

Obtain signatures of acknowledgement and route to Nursing along with the registration form.

All information regarding Advance Directives should be maintained in the patient's electronic medical record.

Effective Date: 07/04
Reviewed: 11/07, 09/13, 07/14
Revised: 11/07, 09/13, 07/14

Cochise Regional Hospital
Business Office Policies

Notice of Non-Coverage

POLICY

It is the policy of Southeast Cochise Regional Hospital to notify patients when items and/or services requested may be non-covered.

PROCEDURE

At the time of admission, patient will be informed of any possible non-covered items prior to receiving services.

In order for services to be rendered, patient is required to sign appropriate documentation (ABN form and Promissory Note) making themselves financially responsible.

Bill intermediary as requested by the patient.

If denied by the insurance company or intermediary, bill patient for total charges.

Note all information in the patient account.

Effective Date: 07/04
Reviewed: 11/07, 12/08, 07/14
Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
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Patient Valuables

POLICY

It is the policy of Cochise Regional Hospital to provide a safe, secure area for patient valuables. However, patients are to be strongly encouraged to leave their valuables at home or in the custody of a relative. The hospital will have no responsibility for any personal belongings not placed in the safe.

PROCEDURE

Deposit

Upon registration, the patient should be asked if they have valuables, such as:

- Credit cards
- Jewelry
- Money in excess of \$5
- Medications

A Valuables Envelope with the patient's account number, date of service, and name.

List of all valuables being deposited on the envelope:

- All jewelry must be described by appearance only, such as:
 - Yellow metal ring with single clear stone.
 - Silver colored bracelet with five turquoise colored stones.
- Money must be counted in front of the patient before being deposited in the valuables envelope. If the dollar amount exceeds one hundred dollars, a witness must also verify the amount.

Obtain the patient's signature on the envelope and sign the envelope with your name and title. A third party should witness the signature. Explain to the patient that this receipt should only be surrendered when retrieving valuables.

Place valuables in envelope in presence of patient and witness, and seal.

Document the valuables envelope number in patient account generated from the system.

Place valuables envelope in the safe.

A log of all valuables will be kept by the Business Office

- Patient name
- Hospital account number
- Description of contents
- Date deposited
- Name of employee obtaining valuables and person witnessing signature

Withdrawal

Compare receipt number to envelope number.

Request identification to verify the patient's identity.

Authorization from the patient must be presented with the receipt if anyone other than the patient retrieves the valuables. Compare the signature to the valuables envelope.

In the presence of the patient, open the valuables envelope. Check off each item withdrawn using the list on the back of the envelope, and have the patient initial receipt of each item. If any items are missing, contact a supervisor immediately.

The emptied envelope will be retained in the patient billing chart.

The Log will be noted with the date of retrieval.

Should a patient request articles from valuables envelope during their stay, a new envelope will be prepared following the deposit procedures.

Unclaimed Valuables

The Log will be compared to the discharge list daily.

If a patient has been discharged, two attempts will be made to contact the patient by phone, followed by a certified letter. If the patient fails to retrieve the valuables at that time, contact the State Unclaimed Property Division for instructions.

Expired Patients

If there is an estate executor, with proper documentation, the valuables can be released to that person, following presentation of documentation stating estate executor responsibility.

Effective Date: 07/04
Reviewed: 11/07, 12/08, 09/13, 07/14
Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Billing

POLICY

Cochise Regional Hospital is committed to processing initial claims within five days from discharge to ensure prompt reimbursement.

PROCEDURE

Electronic Claims

Claims will be downloaded on a daily basis and will be billed through clearinghouse.

Verify insurance information.

Verify occurrence codes and dates.

Review failed edits and correct errors.

Medicaid patients are excluded from receiving bills except for non-covered services, out of state Medicaid patients will be treated as self pay.

A report will be generated in clearinghouse and from this report acceptance of bill dates from insurance companies will be entered in comments section in financial system.

Electronic submission of claims will be done daily.

Edit reports will be reviewed daily by billers and supervisor to assure all claims are sent out daily.

Manual Claims

A limited amount of secondary payer claims will be submitted manually.

Large dollar claims, biller should contact payer to verify receipt of claim.

Enter bill dates in system.

All claims will be billed daily.

Those claims necessary to mail will be mailed daily.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

HMO/PPO Contracted Accounts

POLICY

It is the policy of Cochise Regional Hospital to perform account follow-up 15 to 30 days from billed date to expedite prompt payment.

PROCEDURE

Contact carrier for status at fourteen (14) days post billing to determine receipt of claim and approximate processing time frame.

Claims not received by carrier should be faxed or sent certified/overnight mail to the claims department to the attention of the claims examiner.

At a minimum, contact payer every 30 days for claim status. For claims over \$1,000.00, minimum follow-up should be every fourteen (14) days.

All claims not resolved within sixty (60) days of billing should be reviewed by the supervisor or manager for intervention/additional guidance.

Should the insurance company fail to pay the claim timely, the contract should be consulted for payment guidelines and appeals/penalties associated with the agreement.

Advise CFO of any ongoing problems with delayed/no payment situations from contracted payers.

Effective Date: 07/04
Reviewed: 11/07, 12/08, 07/14
Revised: 07/14

Cochise Regional Hospital
Business Office Policies

Account Follow-Up: Group Insurance

POLICY

It is the policy of Cochise Regional Hospital to perform account follow-up 15 to 30 days from billed date to expedite prompt payment.

PROCEDURE

Claims over \$65.00

Contact carrier for status at fourteen (14) days post billing to determine receipt of claim and approximate processing time frame.

Claims not received by carrier should be faxed or sent certified/overnight mail to the claims department to the attention of the claims examiner.

At a minimum, contact payer every 30 days for claim status. For claims over \$1,000.00, minimum follow-up will be every fourteen (14) days.

All claims not resolved within sixty (60) days of billing will be reviewed by the supervisor or manager for intervention/additional guidance.

Claims not resolved within sixty (60) days are considered delinquent. The patient (or guarantor) will be notified of the insurance company's non-payment.

In the event the insurance company fails to make payment or notify the facility of the reason for delayed or non-payment, the state insurance commission office (if applicable) will be contacted. Patient will be instructed to do likewise.

Accounts Under \$250.00

At 60 days post billing, the biller should run an A/R report of all insurance accounts under \$250.00.

All correspondence will be answered on an on-going basis. Claims with outstanding issues will be worked accordingly.

A/R report review and financial class changed to self-pay (F/CE) on those accounts where patients are responsible for the co-pay or deductible.

Effective Date: 07/04
Reviewed: 11/07, 12/08, 07/14
Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Account Follow-Up: Worker's Compensation

POLICY

It is the policy of Cochise Regional Hospital to perform account follow-up 15 to 30 days from billed date to expedite prompt payment.

PROCEDURE

Claims over \$65.00

Contact carrier for status at fourteen (14) days post billing to determine receipt of claim and approximate processing time frame.

Claims not received by carrier should be faxed or sent certified/overnight mail to the claims department to the attention of the claims examiner.

At a minimum, contact payer every 30 days for claim status. For claims over \$1,000.00, minimum follow-up will be every fourteen (14) days.

All claims not resolved within sixty (60) days of billing will be reviewed by the supervisor or manager for intervention/additional guidance.

Claims not resolved within sixty (60) days are considered delinquent. The employer should be notified of the workers' compensation carrier's non-payment. Employer will be further notified that they are responsible for payment of the account.

In the event the workers' compensation carrier fails to make payment or notify the reason for delayed/non-payment, the state insurance commission office (if applicable) or workers' compensation board should be contacted.

Contact patient to get assistance with regard to employer getting a claim number from the State.

Advise CFO of any employer that consistently denies or prolongs payment.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Account Follow-Up: Medicare/Medicaid

POLICY

It is the policy of Cochise Regional Hospital to perform account follow-up 15 to 30 days from billed date to expedite prompt payment.

PROCEDURE

Claim review will occur thirty (30) days post billing.

Check on line DDE system or contact intermediary.

Review and take appropriate action on denied/suspended claims on remittance advices (all denied/suspended claims will be resubmitted within three (3) working days).

Payment received - to billing for processing of deductibles and co-insurance, or initiate financial class change to self-pay, if the patient is responsible.

AHCCCS

Claim review will occur thirty (30) days post billing.

Contact intermediary for claim status.

Review and take appropriate action on denied/suspended claims on remittance advices (all denied/suspended claims will be resubmitted within three (3) working days).

Re-submit claim if applicable.

Effective Date: 07/04
Reviewed: 11/07, 12/08, 07/14
Revised: 11/07, 07/14

Cochise Regional Hospital
Business Office Policies

Secondary Billing

POLICY

It is the policy of Cochise Regional Hospital to file secondary insurance claims within five (5) days of receipt of initial payment from primary insurance.

PROCEDURE

Once the cashier posts cash to patient, a copy of the remittance advise is made and forwarded to the billing unit.

Within five (5) days, the billing unit forwards to the secondary carrier.

Monthly, the A/R report is reviewed for any outstanding unbilled insurance. Accounts with prior payments and unbilled secondary insurances are audited for proper disposition of the bill.

Once completed, the hospital information system is updated with the new billing date.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 10/13, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Cash Reconciliation - Cash Receipts - Audit Trail

POLICY

It is the policy of Cochise Regional Hospital to expedite processing of cash receipts and to ensure an audit trail is in place for the receiving, reconciling, posting and deposit of cash receipts.

PROCEDURE

Cash Receipts

Checks are verified for totals and EOB information are copied.

All checks received and made out to the hospital will be deposited.

Check copies are tallied and compared to the original tape.

The account number as well as the amount to be posted is highlighted.

If system doesn't compute contractual, enter this amount on the R/A and highlight.

Batch each payer group separately (i.e., Medicare, Medicaid, Insurance, Self-pay).

Scan Daily Cash Activity.

All cash receipts are to be posted within 24 hours, with checks deposited on the day of receipt.

All cash receipts will be kept and the rest of the daily deposits once this is balanced

All cash will be kept in a safe.

All cash from other areas (i.e., cafeteria, clinics) will be deposited with the cashier on a daily basis.

Audit Trail

Mail receipts are opened and a tape run by employee #1.

Cashier reconciles mail receipts and cash, verifying patient account numbers and general ledger numbers for contractals and miscellaneous cash.

Copy of reconciled tape is attached to daily cash sheet and forwarded to Fiscal Department.

The data entry clerk enters transaction to the online system.

The deposit is routed to the bank in a locked bag by employee #2. This may be done prior to posting.

A copy of the duplicate deposit slip is routed to Fiscal Department to compare with the reconciliation tape.

If the cashier is allowed to post receipts, then the cashier should run the cash summary report and balance to the initial tape.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 09/13, 07/14

Revised: 11/07, 12/08, 09/13, 07/14

Cochise Regional Hospital
Business Office Policies

Account Adjustments

POLICY

It is the policy of Cochise Regional Hospital to process all adjustments after proper approvals utilizing appropriate codes to accurately transfer to the General Ledger.

PROCEDURE

Contractual Adjustments

Adjustments that are "fixed" in nature, governed by regulation, law or contractual agreement are to be posted by cashiers daily.

These adjustments occur as part of the normal cash receipts operation and do not require approval process.

Adjustment

Adjustments which are to be considered arbitrary or judgmental in nature such as charity care, employee discounts, administrative adjustments, flat rate allowance, balance transfers, bad debt, and write off need approval.

The approval process is:

All	Chief Financial Officer
Bad Debts	Chief Financial Officer
Other	Chief Financial Officer/Business Office Manager
Small Balances	Written off every 30 days

Ensure appropriate approval levels are obtained prior to applying adjustments.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 09/13, 07/14

Revised: 11/07, 12/08, 09/13, 07/14

Cochise Regional Hospital
Business Office Policies

Unidentified Cash

POLICY

It is the policy of Cochise Regional Hospital to insure proper cash controls are in place for checks/cash received that cannot be identified at the time of deposit.

PROCEDURE

An account is opened to capture all unidentified checks/cash that cannot be identified with an open or bad debt account.

All cash/checks not identified will be reviewed with the Business Office Coordinator and only if approved by Business Office Coordinator and/or Chief Financial Officer, then cash will be posted to an open A/R account titled "Deferred".

The Chief Financial Officer is to be advised of the amount of cash received and consulted on its proper disposition.

Immediate review of cash management/control should be initiated to prevent additional occurrences.

Monthly, the deferred account should be reconciled to zero.

Cash controls should be reviewed and information there should be consistent and identify any on-going cash identification problems.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 10/13, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Insufficient Fund Checks

POLICY

It is the policy of Cochise Regional Hospital to pursue repayment of returned checks for insufficient funds.

PROCEDURE

Once the check is returned for NSF, a \$25.00 fee will be charged to the patient account the check will be forwarded to Collections. Collections will contact the bank to determine if funds are now available to clear the check; if funds are verified, redeposit.

Unclaimed returned checks should be adjusted to the account by a reversal of the payment and a \$25.00 NSF fee added to the account.

If the check is still determined to be insufficient, the patient should be requested to remit the cash amount within two (2) working days.

Present the check to the bank for collection. (If the patient makes a deposit, the bank will withhold enough to cover the check.)

If the bank is unable to collect, immediate referral of the amount to the facility's collection agency should result. The payment is removed from patient's account immediately and check forwarded to Collections within 24 hours. Cashier will apply a non-sufficient funds charge to patient's account.

All information in regards to the returned check will be documented on the system.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Remittance Advice Maintenance

POLICY

It is the policy of Cochise Regional Hospital to maintain Medicare, AHCCCS and other payers who pay for multiple patients on the same voucher in date order by the Business Office.

PROCEDURE

File EOBs in filing cabinet in date order entering.

Date stamp EOBs with posting date to expedite account research.

Retain EOBs as mandated by federal and state regulations.

Effective Date: 07/04
Reviewed: 11/07, 12/08, 07/14
Revised: 11/07, 07/14

Cochise Regional Hospital
Business Office Policies

Payment Monitoring - HMO/PPO

POLICY

It is the policy of Cochise Regional Hospital to maintain compliance of contracted payers to contract terms.

PROCEDURE

HMO/PPO Payment Monitoring

A unique payment and contractual code should be established for each major contracted payer.

The Payer File must be monitored by billers for:

- Timely payment of clean claims
- Payment for types of services
- Any stop losses or catastrophic provisions
- Payment inclusions
- Renewal dates for contracts

Upon receipt of payments, the cashier will compare each payment to the account cycle for appropriateness. Any payments that deviate are to be copied, appropriately noted, and forwarded to the Billers to follow up with insurance for appropriate payment.

The Billers will review the payment against the contract. If the payment is indeed an error, the claim will be resubmitted for the correct payment.

All trends in payment errors will be appropriately documented and forwarded to the attention of the Billing Team Leader. If issue progresses, then this will be addressed to the Business Office Coordinator.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Refunds

POLICY

It is the policy of Cochise Regional Hospital to refund overpayments when appropriate.

PROCEDURE

Refund request form, supporting documentation, check request, and backup is submitted to the Business Office Coordinator for approval.

Automated processing of refunds must be approved by the Chief Financial Officer.

Accounts payable will disperse check to the patient and/or insurance carrier in a timely manner.

Proper adjustment is placed on the patient account with supporting documentation maintained manually or online by the Cash Poster

Check copies are maintained in the Accounts Payable Department.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 10/13, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Self-Pay Discount Structure (No Insurance Involved)

PURPOSE

At time of service or within 10 days with no debt accounts in system.	20% discount
At time of service with bad debt account in system. (Must pay bad debt or make payment arrangements, and pay 1 st payment to get discount)	20% discount
Bad debt account holders if payment made within 10 days and bad Debt also resolved.	10 % discount - NEW 5% discount- w/payments
Within 30 days with no bad debt accounts in system.	20% discount
Within 30 days with bad debt accounts in system. (Must pay bad debt or make payment arrangements, and pay 1 st payment to get discount)	10% discount
Within 60 days with no bad debt accounts in system	10% discount
Within 90 days with or without bad debt accounts in system.	10% discount
Within 90 days with bad debts in system (Must pay bad debt or make payment arrangements, and pay 1 st payment to get discount- give same 10% discount on bad debt – paid in full 0 for payments)	10 % discount
Any other discounts or arrangements for payment/officers must be approved by the Chief Financial Officer.	

Effective Date: 04/91
Reviewed: 11/07, 12/08, 07/14
Revised: 07/04, 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Collections - Self Pay Balances

POLICY

It is the policy of Cochise Regional Hospital to resolve all self pay balances in a timely manner.

PROCEDURE

Upon determination of the patient due amounts, the following should be in place:

SELF PAY

An initial bill will be sent for the balance to the patient.

Accounts will be referred to the collector for review. Items to be reviewed are as follows:

- Any other open accounts with insurance information.
- Prior history of bad debt.
- Possible qualification for Medicaid/other indigent programs.

All accounts will receive monthly data-mailers with current balance due.

Once accounts have reached 90 days old, they are considered delinquent. At this time, a final notice will be sent to all patients with outstanding balances.

On balances \$250.00 and over, telephone contact must be made with the patient/guardian according to the following schedule:

- 30 days If no response, continue to call documenting each contact/or attempt to contact. (3 calls) If patient wishes to set up a payment plan, document and set it up on the system.
- 90 days If payment is not received and patient has not set up a reasonable payment plan or has defaulted on the payment plan, a final notice is sent listing the balance due and possible collection action.

- 120 days Account is reviewed for collection agency placement.

Self-pay, after insurance payment, will be tracked under a special financial class E.

Patients/guarantors will have 30 days to pay balance due or set up satisfactory payment arrangements.

- At 30 days post insurance payment, patients will receive a notice requesting payment or to call the Business Office.
- At 45 days post insurance payment, patient will receive a past due letter.
- At 52 days post insurance payment, a phone call will be placed to the patient.
- At 60 days post insurance payment, patient will receive a final notice.
- At 90 days post insurance payment, patient account will be transferred to collections agency, after approval.

PAYMENT PLAN

Always attempt to collect the "total amount due". Do not offer payment plan unless patient is unable to pay total amount.

Payment plans should not exceed one year.

If patient is unable to meet the above guidelines, the patient/guarantor must complete a financial statement for extended payments. Approvals for reduced payments must be made by the Chief Financial Officer and Business Office Coordinator.

Patients meeting above guidelines are transferred to financial class Y,E,EE for tracking of this receivable. The attached promissory note will be completed if patient is available. If the patient is unavailable, send a confirmation notice to guarantor of account.

Monthly, the financial counselor should review financial class Y,E,EE for delinquent/defaulted accounts.

If a patient defaults on payment schedule, a final notice is sent and the account forwarded (after 30 days) to the selected collection agency.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Bad Debt

POLICY

It is the policy of Cochise Regional Hospital to make every reasonable effort to collect all monies owed to the hospital prior to collection agency referral.

PROCEDURE

Using all information gathered at the time of admission, as well as any additional information obtained post discharge, the patient accounting staff can determine the collectibility of the account. Some indicators of bad debt accounts:

- Moved, no forwarding address.
- Telephone disconnected; no other number.
- Fraudulent name, address and/or insurance information.
- Payment plan default.
- No response to inquiries for information.
- Failure to complete Charity Care, Medicaid or other financial aid application.
- Prior history of bad debt.
- Administrative decision.

Once the determination has been made to process account to bad debt, the following process will occur:

- Medicare Bad Debts will be separated from private pay Bad Debts (see Medicare Bad Debt policy).
- Staff will write up accounts for adjustment, or request system generated account status, providing all documentation.
- The Business Office Coordinator will review all documented history on the account.
- Lack of facility follow through should warrant further work up prior to authorization of write off.

Approval levels:

Business Office Coordinator: Up to \$250.00

Copy of bad debt adjustments forwarded to the Chief Financial Officer monthly for tracking of total write off.

Bankruptcy accounts will be adjusted off receivables. These accounts will not be forwarded to the collection agency.

Forward approved adjustment sheet to assigned personnel.

Monies received on accounts in Bad Debt will be applied to the recovery account in the General Ledger or applied to individual accounts through the bad debt menu. All payments and adjustments received from the collection agency will be reconciled on a daily basis when payment comes in.

Agency account returns will be either referred for second placement or adjusted off the bad debt system.

The Chief Financial Officer will approve any legal action to be taken by the agency.

All efforts will be extended to clear all bad debts off the account receivable by 150 days.

Effective Date: 07/04

Reviewed: 11/07, 12/08, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Medicare Bad Debt

POLICY

It is the policy of Cochise Regional Hospital to secure reimbursement of deductibles and co-insurance deemed to meet the criteria of bad debt by maintaining accurate, complete information.

PROCEDURE

Following collection referral guidelines, refer bad debt Medicare accounts to an outside agency.

Ninety days post referral; the agency will cancel and return Medicare account with no activity. (Utilize separate account number for Medicare.)

Maintain supporting documentation (i.e., UB, collection agency, agency acknowledgment and cancellation, remittance advices).

To qualify deductibles and co-insurance for patients with AHCCCS, the facility must bill AHCCCS and receive partial payment or denial due to maximum allowable guidelines. These accounts will not be forwarded to a collection agency.

NOTE: Provider-based physician services cannot be claimed as Medicare bad debt.

Effective Date: 07/04
Reviewed: 11/07, 12/08, 07/14
Revised: 11/07, 07/14

Cochise Regional Hospital
Business Office Policies

Collection Agency Audits

POLICY

It is the policy of Cochise Regional Hospital to perform quarterly audits of accounts to ensure appropriate and consistent follow-up is performed by the collection agency.

PROCEDURE

Thoroughly audit twenty-five (25) accounts.

Contact agency to schedule audit.

DO NOT submit the list of accounts prior to scheduled audit.

Select accounts which will indicate agency involvement, consistency and professional conduct, such as:

- Large dollar accounts resolved within one or two months of arrival.
- Disputed accounts.
- Accounts with customer complaints.
- Accounts for which legal action has been pursued and payment not yet received.

Follow-up within ten (10) days with a written report detailing results of the audit.

Log findings on Collection Agency Audit Log.

Effective Date: 07/04
Reviewed: 11/07, 07/14
Revised: 11/07, 07/14

Cochise Regional Hospital
Business Office Policies

EXHIBIT A

Federal Fair Debt Collections Practices Act

Cochise Regional Hospital
Business Office Policies

Hospital Financial Policy

POLICY

In order to provide our community with cost effective health care, Cochise Regional Hospital must insure payment for services rendered through billing of third party payers and collection of self-pay accounts in a timely, efficient customer sensitive manner.

PROCEDURE

At the time of service, or during the pre-registration process, patients will be requested to provide documented evidence of insurance coverage and proper identification.

Coinsurance and deductibles should be collected at time of service if information is available.

Second opinions, pre-authorization, etc., should be verified with the patient/physician office/insurance payer prior to the hospital stay. Coordination of this process with the physician office is essential to capturing this data efficiently.

Auto accidents and other third party liabilities are billed on a limited basis. If litigation is sought in determining fault, liens and letters of protection will not be accepted in lieu of payment. Patients will be requested to pay the balance in full or provide a subrogation agreement to bill their group insurance carrier.

Self-pay admission/self-pay balances (coinsurance, deductibles) should be collected at the time of service. Self-pay portions not paid at the time of service should be handled per the "Collection Self-Pay Policy and Procedure".

To assist patients in understanding the hospital financial policy, a copy will be distributed at the time of services.

Every effort should be made to provide financial counseling to patients unable to meet their financial obligations. Counseling should include screening for:

- AHCCCS
- Charity Care
- Trust Funds, if applicable
- Children Services Programs
- Other county, state or local programs

Effective Date: 07/04

Reviewed: 11/07, 12/08, 07/14

Revised: 11/07, 12/08, 07/14

Cochise Regional Hospital
Business Office Policies

Charity Care

POLICY

Cochise Regional Hospital provides health care to eligible patients without charge or at a reduced rate. Eligible patients include all patients, regardless of race, religion or national origin, who meet the financial guidelines set forth in the current poverty guidelines and are not eligible for state Medicaid.

PROCEDURE

Coverage will be retroactive for three months prior to the receipt of the completed application by the Patient Financial Services Department. Completed application may include:

- a. Financial statement, signed and dated.
- b. Three months pay stubs from current employer.
- c. Most recent tax return.
- d. Any other documentation to support financial need.

On receipt of the completed application, a decision will be made within five (5) working days.

Applicants liability will be determined by the current poverty guidelines.

Applicants will be notified by letter of the decision. Applicants may request a review of denial or partial denial within thirty (30) days of receipt of the notice.

Approved applicants will only be valid for three months. An updated application must be made for continued coverage.

Once approval has been granted, all applicable accounts will be adjusted using the "Charity Care" adjustment code.

All applications must be maintained by year in a locked file drawer pending future audits.

Effective Date: 07/04
Reviewed: 11/07, 07/14
Revised: 11/07, 07/14

Cochise Regional Hospital
Business Office Policies

Time Payment Accounts

POLICY

If payment arrangements are agreed upon, the account will be revised to the financial class assigned to time payment accounts and the account will be assigned to that accounts receivable category. These accounts must be monitored on a monthly basis by printing a report showing A/R balances by date of last payment. If a patient defaults on payment arrangements, the account will be written off to the appropriate bad debt financial class and sent to an outside collection agency.

UNDER NO CIRCUMSTANCES SHOULD AN ACCOUNT BE ALLOWED TO REMAIN IN THIS CATEGORY BEYOND 30 DAYS FROM LAST PAYMENT.

Accounts which recently posted third party payer payments must be revised to this accounts receivable category to allow the patient additional time to pay their share of the cost.

The patient will be notified of recent receipt of insurance payment and advised of a date payment of their share is expected. The account is then revised to time payment category and set up for one payment expected for the total amount due.

In the event the patient share due is a large amount, a payment arrangement may be approved and the account will be reviewed as any other time payment account.

UNDER NO CIRCUMSTANCES SHOULD A PATIENT SHARE AFTER INSURANCE PAYMENT BE ALLOWED TO CONTINUE ON ACCOUNTS RECEIVABLE BEYOND 30 DAYS FROM LAST PAYMENT.

Effective Date: 07/04
Reviewed: 11/07, 12/08, 07/14
Revised: 11/07, 07/14

Cochise Regional Hospital
Business Office Policies

Late Charges

POLICY

It is the policy of Cochise Regional Hospital to track; monitor and resolve late charge trends. Late charges are defined as any charges received and keyed by Data Processing after the suspense or hold days from discharge to bill drop elapses.

PROCEDURE

Monitoring and Correction

A daily Late Charge Report is to be generated. If an automated late report is unavailable, use the manual Data Processing Late Charge Report.

Summarize each departments total late charges.

A copy of each days late charge report is to be forwarded to the clinical departments in question.

The CFO and ancillary departments will review late charges to determine the reason for delinquencies and provide corrective action.

A weekly summary by department will be forwarded to the CEO and CFO for review.

Billing

All late charges on unbilled accounts are to be included in the final billing.

Total late charges under \$25.00 received on billed accounts may be written off using the appropriate adjustment/transaction code.

Total late charges over \$25.00 must be billed unless the primary reimbursement will be one of the following types:

- Per Diem
- DRG
- Flat Rate

Effective Date: 07/04
Reviewed: 11/07, 07/14
Revised: 11/07, 07/14

Cochise Regional Hospital
Business Office Policies

Bad Debt Write-Off Policy

POLICY

It is the policy of Cochise Regional Hospital to write off a patient balance as soon as adequate collection efforts have been made and the account has been determined to be uncollectible, providing all efforts are documented and proper authorization has been obtained. All accounts written off should be forwarded to an outside collection agent except:

- A. When legally prohibited
- B. When payment at a future date is probable.
- C. When balance is less than collection agency minimum.
- D. When it has been established there are absolutely no assets and patient has expired.

In order to allow time for adequate collection efforts and to systemically protect increases in bad debt reserve, it is recommended that accounts not be written off until 150 days from discharge. Any accounts written off before 150 days are to be carefully evaluated and approved by the Chief Financial Officer.

ADEQUATE FOLLOW-UP IS DEFINED AS FOLLOWS:

- A. Accounts over small balance and under \$100.00:
 - 1. At least three (3) automatic statements (system generated once a month) have been sent to the patient/responsible party.
 - 2. Mail returns and address corrections have been properly researched and the patient/responsible party has received at least two (2) statements at the most current address.
- B. Accounts over \$100.00 and under \$500.00:
 - 1. At least four (4) automatic statements (system generated once a month) have been sent to the patient/responsible party.

2. Mail returns and address corrections have been properly researched and the patient/responsible party has received at least three (3) statements at the most current address.

3. All assigned insurance claims have been properly filed and have made appropriate payments. Denial after 45 days from date of filing and a minimum of one (1) contact has been made.

4. Telephone contact with the patient/responsible party has been completed one (1) time or three (3) attempts have been unsuccessful in a 14 day period.

C. Accounts over \$500.00 and under \$2,000.00:

1. At least four (4) automatic statements (system generated once a month) have been sent to the patient/responsible party.

2. Mail returns and address corrections have been properly researched and the patient/responsible party has received at least three (3) statements at the most current address. The research will include the documentation of skip tracing.

3. All assigned insurance claims have been properly filed and have made appropriate payments. Denied claims or have failed to make payments or denial after 45 days from date of filing and a minimum of three (3) contacts has been attempted.

4. Telephone contact with the patient/responsible party has been completed two (2) times or four (4) attempts have been unsuccessful in a 14 day period.

D. Accounts over \$2,000.00:

1. At least four (4) automatic statements (system generated once a month) have been sent to the patient/responsible party.

2. Mail returns and address corrections have been properly researched and the patient/responsible party have received at least three (3) statements at the most current address. The research will include the documentation of skip tracing.

3. All assigned insurance claims have been properly filed and have made appropriate payments. Denied claims or failure to make payment 45 days after the initial filing date and a minimum of four (4) contacts have been completed to the insurance company.

4. Telephone contact with the patient/responsible party has been completed two (2) times or four (4) attempts have been unsuccessful in a 14 day period. In addition, any other available telephone numbers have been attempted (i.e., employer, emergency contact, relative, neighbor, etc.)

E. MINIMUM WRITTEN APPROVAL OF ACCOUNTS WRITTEN OFF OVER 180 DAYS FROM DISCHARGE - SIGNATURES ARE REQUIRED PRIOR TO TURNOVER.

1. Small balance accounts (defined as accounts under \$25.00):
 - Automatic write off
2. Accounts over small balance amount and under \$1,000.00:
 - Chief Financial Officer
3. Accounts over \$1,000.00 and under \$5,000.00:
 - Chief Financial Officer
4. Accounts over \$5,000.00 and under \$10,000.00:
 - Chief Financial Officer
 - Administrator
5. Accounts over \$10,000.00:
 - Chief Financial Officer
 - Administrator
 - Board of Directors

Effective Date: 07/04
Reviewed: 11/07, 12/08, 07/14
Revised: 11/07, 07/14

Cochise Regional Hospital
Business Office Policies

Charity Write-Offs

POLICY

It is the policy of Cochise Regional Hospital to maintain a consistent methodology in identifying Charity Care at the hospital. The following factors should go into defining charity write-offs:

1. Demonstrated inability of the patient to pay determined through financial status of a patient (i.e., collection efforts, credit reports and employment status, collection agency).
2. Catastrophic hospitalization costs that significantly weakens the ability of a patient to pay the bill in full.
3. Uninsured patients that are unable to pay based on means testing on local conditions.
4. Emergency patients if the hospital's inability to assess a patient's financial condition prior to rendering services but subsequently when means tested found to be unable to pay.
5. Long standing local citizen who has a proven track record of paying their bills is forced financially to make part payment of bill but exhausted all resources to pay in full.

IDENTIFYING CHARITY CARE

- A. Gross Income should fall within established or recognized standards for determination of poverty level, considering family size, geographic and any other pertinent variables.
- B. Net Worth should be considered (i.e., all liquid and non-liquid assets, less liabilities and claims against assets).
- C. Employment status.
- D. Family size.

- E. Unpaid bill after applying for Medicaid, welfare or other third party sources.
- F. Age of the account and collection efforts taken.
- G. Non-covered days from Medicaid.
- H. Use collection agency data and input to identify "inability to pay" if necessary.

Timing criteria is established on determination of inability to pay.

Note: * Administration and Professional courtesy allowances do not qualify as charity care.

- Means testing is defined as sources of income, i.e., Social Security, public assistance, ability to borrow, copies of W-2.

Effective Date: 07/04
Reviewed: 11/07, 12/08, 07/14
Revised: 11/07, 07/14

Cochise Regional Hospital
Business Office Policies

Customer Complaint

POLICY

It is the policy of Cochise Regional Hospital that all patient complaints and concerns will be addressed immediately.

PROCEDURE

Complaints received by Administration or other hospital personnel regarding billing or collection will be referred to the Business Office Coordinator.

The complaints will be researched and resolved within three (3) days to the satisfaction of the patient and the hospital.

For significant complaints, the patient will be requested to submit their complaint in writing. Written complaints will be responded to within one week.

An incident report with supporting documentation of the complaint will be completed and routed to the Director of Operations.

Inability to effectively resolve the customer complaint will be referred to the Director of Operations.

The Chief Financial Officer will only be involved in complaints regarding the Business Office where all other lines of communication have failed.

Patient complaints regarding dissatisfaction with medical services will be referred directly to the Director of Operations for resolution.

Effective Date: 07/04
Reviewed: 11/07, 12/08, 07/14
Revised: 11/07, 07/14

Cochise Regional Hospital
Emergency Department

Self Pay Procedure

ER Registration clerks will identify patient as Self Pay after an ER Physician's initial physical exam.

Immediately after the patient receives the discharge verbal and written instructions from the ER nurse, the ER Nurse will refer the patient back to the Registration Clerk to pick up any prescriptions for medicine.

The Registration Clerk will then State the Medical Services that have been rendered and according to Cochise Regional Hospital policy states; Payment in full is due IMMEDIATELY AFTER ER medical services are delivered.

If patient has medical insurance and the co-payment has been collected then the Registration Clerk will give the patient/family the prescription written by the ER doctor and send patient/family home.

If the patient has no medical insurance or does not provide the insurance co-payment, the registration clerk explains the patient will be placed in the hospital self pay program until they can provide insurance eligibility (medicaid, medicare or 3rd party insurance)

Registration Clerks will then refer the patient/family to the Eligibility Clerk in order to apply for AHCCCS aka a Medicaid card (after hour's patient will complete paper application and admitting will fax application to DES office)

In the meantime, \$225.00 are due for ER services rendered, and the Registration Clerk will make the patient aware of the discounted rate since emergency room visits average charge is approximately \$1,200 per patient. The unpaid balance of the hospital medical bill will be written off as Charity Care and there will be no attempt by the hospital to collect the remaining balance of the medical bill.

If payment is received, the Registration Clerk provides the patient/family with prescriptions written by the ER Doctor.

If no payment is received, only ER discharge instructions are provided to the patient/family and NOT the prescription. In addition, **a LIST OF FREE CLINICS and other emergency departments in the areas are given on a pre-printed document that includes Phone Numbers and Address in the AREA.**

The patient and family at any time 24 hours per day can return to the Hospital Registration Clerk and pay the hospital ER discounted fee of \$225 to have ER medical discounted and immediately receive the prescriptions written by the doctor.

In-Patient Admission Registration Policy and Procedure

When electronic order from Emergency Room doctor indication patient transfer from Emergency Room to Inpatient or Observation Status; Registration staff is responsible for changing patient status in Electronic system.

- Registration staff should obtain Electronic Signatures from Patient at Bedside.
- Registration Staff should run Eligibility for Inpatient Benefits.
- Registration Staff is responsible for notifying Insurance Company of Inpatient or Observation Stay by Faxing face sheet to Pre-Authorization department (fax confirmation sheet should be scanned to patient's chart and a copy to Financial counselor for follow up).
- In the event patient is Self pay, follow Self Pay Policy for Inpatient stay. Financial Counselor should be notified of any self pay patient.
- Financial counselor is responsible for calling Insurance Company to obtain an Authorization or reference number for Inpatient or Observation stay.
- For additional or Complex Clinical questions review the Clinical NOTES by Dr. Luciano Fochesatto.
- Nurse in charge is responsible for answering any CLINICAL questions related to patient care. If no nurse is available questions should be referred to ER Doctor.
- For Additional or Complex Clinical questions contact Dr. Luciano Fochesatto-CMO.
- When a Authorization is obtained should be entered in case in order to bill.
- **If Authorization is denied IMMEDIATELY contact Ricardo Perez Team**

Any problems should be immediately reported to Business Office Manager or Director of Operations.

Effective: 06/14
Reviewed: 07/14
Revised: 07/14

Down Time Procedure

In the event electronic system is not available all registrations should be paper. A full registration packet should be provided to patients after patients were triaged in the emergency room.

Maintain a manual log of each patient being manually registered with name, DOB, date/time of services.

Provide a registration sheet in order for patient to fill out Demographic, Insurance, and emergency contact information.

Patient should sign Paper Conditions of Admissions and Patient rights.

Patient should obtain a copy of Insurance cards and Identification card.

Retrieve MR# from spreadsheet (desktop in emergency room computer)

Create labels and provide to department.

If no labels are available for armband, write patients name and DOB in armband.

Maintain all paper charts until electronic system is available and enter registration into system selecting correct date and correct time of service.

Reviewed: 07/14

Revised: 07/14

Inpatient Registration

When Electronic order from Emergency Room doctor indicating patient transfer from Emergency Room to Inpatient or Observation Status; Registration staff is responsible for changing patient status in Electronic system.

Registration staff should obtain Electronic Signatures form Patient at Bedside.

Registration staff should run Eligibility for Inpatient Benefits.

Registration Staff is responsible for notifying Insurance Company of Inpatient or Observation Stay by Faxing facesheet to Pre-Authorization department (fax confirmation sheet be scanned to patient's chart and a copy to Financial Counselor for follow up).

In the event Patient is Self pay, follow Self Pay Policy for Inpatient stay. Financial Counselor should be notified of any self pay patients.

Financial Counselor is Responsible for calling Insurance Company to obtain an Authorization or reference number for Inpatient or Observation stay.

Nurse in charge is responsible for answering any questions related to patient care. If no nurse is available questions should be deferred to ER Doctor.

For Clinical questions contact Dr. Luciano Foshesatto.

When an Authorization is obtained should be entered in case in order to bill.

Any problems should be immediately reported to Business Office Manager or Director of Operations.

Registration Guide

The admitting Department is responsible for all Outpatient and Inpatient registrations. The admitting clerk is the first face patients see when they come in through the door. Remember you are expected to provide quality customer service at all times, not only to patients but also to other agencies such as Arizona Ambulance, Douglas Fire, Life Line, and anyone else involved in patient care following HIPPA guidelines.

For patient registration please remember it is your responsibility to gather as much information as possible from patients. Demographic information, emergency contacts and insurance information need to be entered in system as soon as possible. The accuracy of the information collected impacts future reimbursement from patients and from insurance company, this also impacts patient care.

When a patient comes in with no identification at all, and patient is unconscious, register patient under John or Jane Doe so that patient is in Empower as soon as possible. This is the only time a registration will be allowed with minimal information if no family member

Please review the following steps for verifying insurance information.

Medicare.

Verify Medicare eligibility through passport, please be careful since many Medicare eligible patients are eligible for an HMO plan, when this happens it will indicate in the eligibility report from passport if patient has an HMO plan and it will specify who the HMO carrier is. When you see this, please ask patient for HMO card in order to verify eligibility. In this case, you will NOT register patient under Medicare, you will only register patient under HMO plan as primary insurance.

Medicaid.

Verify eligibility for AHCCCS plan under Arizona Medicaid in passport. Search will indicate what plan patient belongs to. In Cochise County there are currently two plans for acute which are University Family Care and UHC Community Plan, there is one plan for Long Term Care which is Bridgeway Health Solutions of Arizona.

Tip:

Remember AHCCCS is always the payer of last resort; AHCCCS is never primary to other plans.

INS Health Services.

When patients are under custody of Border Patrol or Customs, they are responsible for medical expenses incurred during emergency or inpatient stay.

Border Patrol: INS health Services

Customs: Port of Entry

Agent bringing patient for services should present TAR sheet which indicates patient is under custody.

Fax face sheet to appropriate agency, (Attached fax information)

Workers Comp

When a patient reports a work related injury, a report of physician injury needs to be filled out by patient and physicians. Patient is responsible for providing insurance information at time of services please advise patient he has three days call us back with employer insurance information so that we can submit to appropriate insurance; otherwise he will be responsible for all charges incurred in the emergency room. Please also obtain Supervisors name and phone number for future reference.

Industrial Account

For outpatient services we offer contracts to outside agencies. For example, we have a contract with Chiricahua Clinical for sliding fee patients. Patients under sliding fee are covered for radiology and lab services and in this case we bill Chiricahua. Patients under sliding fee will present an order from provider and will indicate they are under sliding fee. We also have contracts for Drug Screen with other companies and patients present for outpatient services. Please remember industrial accounts DO NOT cover emergency room and order should specify what company should be billed for this type of service.

Tricare

Tricare is insurance for active and retired military. Not only for individual but also family. Please verify eligibility through passport. Please remember the difference between Tricare West and Tricare for Life.

Tricare for Life is for retired military and it is always secondary to Medicare.

Tricare West is for active members of military in the west regions of United States.

Commercaill Plan

Patients under commercial plans generally have co-pay for services that is due at time of service. Please pay close attention to member's insurance card and when you run benefits of how much co-pay will be for service. For emergency rooms please follow self pay policy; DOCUMENT WHY COPAY WAS NOT PAID AT TIME OF SERVICE AND REPORT TO SYLVIA VALDEZ.

If you are not able to verify eligibility and benefits online for any payer, please call the number in the back of the card. Most insurance companies have automated services that will give you this information by voice or fax.

Self Pay Patients

Please follow self pay policy for emergency room patients. For outpatient services patients need to be directed to Sylvia Valdez if order is not STAT. If order is not STAT, patient needs to have services performed first and then be directed to Sylvia for payment.

Corizon

Corizon is insurance for inmates under custody of State and they are eligible for all services under this plan. Please register patients under Corizon with inmate number found in identification care and add AZ at the end.

Signatures

For Emergency room and outpatient services, please have patient sign Conditions of Admissions and Patient Rights in empower clinical.

For inpatient and Observation please have patient sign all inpatient forms.

BANDS

It is policy of Cochise Regional Hospital to band patients for all services. Before placing band verify patients name and date of birth.

Self Pay Procedures

Admitting: Identify patient as self pay.

Admitting refers patient to Eligibility clerk in order to apply for AHCCCS (after hour's patient will complete paper application and admitting will fax application to DES office).

Admitting approaches patient Stating Services have been rendered and as Cochise Regional Hospital policy states; Payment in full is due IMMEDIATELY AFTER medical services are deliver. Admitting explains patient will be placed in self pay program until they can provide the insurance eligibility if they applied for Medicaid. In the meantime, \$225.00 are due for services rendered, and makes patient aware of discounted rate since emergency room visits average \$1,200.00

If payment is received, clerk provides patient with discharge instructions and prescription.

If no payment is received, only discharge instructions and a LIST OF FREE CLINICS Phone Number and Address in the AREA are given and prescription is held until payment is received. Patient signs promissory note.

Note:

When patient is placed in self pay program, patient automatically qualifies for a discounted price of emergency room services and will only be responsible for \$225. (Excluding Physician bill and Radiology fees).

If patient becomes Medicaid eligible: \$225.00 will refund when payment from payer is received.

If patient qualifies for Charity Program: Balance after \$225.00 will be written off as Charity Care.

If patient does not apply for Charity Program: Balance will be written off as prompt pay discount.

Inpatient Registration

When Electronic order from Emergency Room doctor indicating patient transfer from Emergency Room to inpatient or Observation Status; Registration staff is responsible for changing patient status in Electronic system.

Registration staff should obtain Electronic Signatures from Patient at Bedside.

Registration Staff should run Eligibility for Inpatient Benefits.

Registration Staff is responsible for notifying Insurance Company of Inpatient or Observation Stay by Faxing face sheet to Pre-Authorization department (fax confirmation sheet should be scanned to patient's chart and a copy to Financial counselor for follow up).

In the event Patient is Self pay, follow Self Pay Policy for Inpatient stay. Financial Counselor should be notified of any self pay patient.

Financial Counselor is Responsible for calling Insurance Company to obtain an Authorization or reference number for inpatient or Observation stay.

Nurse in charge is responsible for answering any questions related to patient care. If no nurse is available questions should be deferred to ER Doctor.

For Clinical questions contact Dr. Lucaino Fochesatto.

When a Authorization is obtained should be entered in case in order to bill.

Any problems should be immediately be reported to Business Office Manager or Director of Operations.

FAX NUMBERS FOR INPATIENT/OBSERVATION AUTHORIZATION.**United Healthcare**

Medicaid, Commercial and HMO
1-888-899-1499
Observation/Inpatient Service

Phoenix Health Plan

1-602-674-6650
Observation/Inpatient Service

Health Choice

1-800-323-965
ER/Observation. Inpatient Services

University Family Care

1-520-874-3420
Observation/Inpatient Services

TriCare

1-608-301-3226

Bridgeway AHCCCS

1-866-638-6126
ER/Observation/Inpatient Services

Health Net

1-800-840-1097
Inpatient Services

AARP Medicare Complete

1-800-676-4798

BCBS Of Arizona

1-602-864-4274
Observation/Inpatient Service
Observation/Inpatient Service

Mercy Care Plan

1-888-899-1499
Inpatient Authorization Inpatient
Observation/Inpatient Service

INS/Border Patrol

1-520-790-0820
ER/Observation. Inpatient Services

INS/US Customs

520-364-2313
Attention: Margaret Baldenegro
ER/Observation/Inpatient Services

AARP

1-866-756-9733
Inpatient Services

Aetna

1-602-431-7363
Inpatient Services

Humana

1-800-266-3022
(Lab/X ray)

Phoenix Health Plan

602-674-6650
Observation/Inpatient Services

 PHONE NO.

 I C A USE ONLY
 INJURY CODE:

WORKER'S & PHYSICIAN'S REPORT OF INJURY INDUSTRIAL CLAIMS MANAGEMENT

1150 WEST STATE STREET #330, BOISE< ID 83702

INJURED WORKER'S RIGHT TO

An employer who is not self-insured can direct you to a doctor of their choice for ONE visit. After the ONE visit, you may report to a doctor of your choice. REMEMBER: If you make a SECOND visit to the employer's doctor, you have established that doctor as your treating doctor. If your employer is self insured, you may not be allowed to change doctors. SEE INFORMATION SHEET ATTACHED TO THIS FORM FOR FURTHER INSTRUCTIONS.

WORKER'S REPORT

 NAME OF INJURED WORKER
 LAST NAME

FIRST

M.I.

1.

SOCIAL SECURITY NO.

PHYSICIAN'S INITIAL REPORT

2. ADDRESS CITY STATE ZIP

DATE OF BIRTH MO. DAY YR. 4. SEX MALE FEMALE

5. SINGLE WIDOWED DIVORCED MARRIED IF SO, IS SPOUSE EMPLOYED YES NO

A.M.

6. OCCUPATION WHEN INJURED DATE OF INJURY TIME

7. EMPLOYER'S NAME PHONE

NO.

8. OFFICE

ADDRESS CITY STATE ZIP

10. MAILING ADDRESS

11. DESCRIBE **WHERE AND HOW** ACCIDENT OR CAUSE OF DISABILITY OCCURRED (INCLUDING LOCATION AND/OR DEPARTMENT) BY THIS INSTRUMENT I MAKE APPLICATION FOR ALL BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE LAW AND I DO HEREBY CERTIFY, WITH FULL KNOWLEDGE THAT IT IS A CRIME TO MAKE WILLFUL, FALSE STATEMENTS TO OBTAIN COMPENSATION. THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE. I UNDERSTAND I MUST FOLLOW THE INSTRUCTIONS OF MY DOCTOR AND MUST HAVE WRITTEN APPROVAL FROM THE INDUSTRIAL COMMISSION TO LEAVE THE STATE OF ARIZONA OR MY LOCALITY FOR MORE THAN 14 DAYS. FAILURE TO DO SO MAY CAUSE FORFEITURE OF COMPENSATION BENEFITS.

Mo. Day YR.

Date of Signing At City State

FORM ICA 04-0102 76 (REV 92)

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE.

12. DATE OF FIRST TREATMENT _____ MO. DAY YR. _____ HOUR _____ A.M. P.M. _____
 13. LOCATION: HOSPITAL ? OFFICE ? OTHER ? _____
 14. DATE WORKING DISABILITY BEGAN _____ MO. DAY YR. _____ 15. WHO ENGAGED YOUR SERVICES? PATIENT ? EMPLOYER ? OTHER ? _____
 WAS PATIENT TREATED BY ANYONE ELSE? YES ? NO ? _____ IF YES, BY WHOM? _____

COMPLAINTS AND PHYSICAL FINDINGS IN DETAIL: ICD-9 CODE _____ : _____ DIAGNOSIS
 DESCRIBE ANY PRE-EXISTING IMPAIRMENT OR DISEASE AFFECTING PRESENT CONDITION _____

DESCRIBE TREATMENT GIVEN BY YOU: _____ PATIENT IS RIGHT ? LEFT ? HANDED _____

WERE X-RAYS TAKEN? YES ? NO ? IF YES, BY WHOM _____ WHEN _____
 WAS LABORATORY WORK DONE? YES ? NO ? IF YES, BY WHOM _____ WHEN _____

X-RAY DIAGNOSIS (ATTACH ROENTGENOLOGICAL REPORT FORM): _____
 WAS PATIENT HOSPITALIZED? YES ? NO ? IF YES, WHERE _____ MO. DAY YR. _____
 DATE OF ADMISSION TO HOSPITAL _____ 27. DATE OF DISCHARGE _____

28. IS FURTHER TREATMENT NEEDED? YES ? NO ? IF YES, FOR HOW LONG _____
 IS PATIENT, AS A RESULT OF CONDITIONS DUE TO THIS ACCIDENT: (A) SUBJECT TO SUSTAIN A PERMANENT DEFECT OR IMPAIRMENT? YES ? NO ?
 ABLE TO DO THE SAME TYPE OF WORK HE PERFORMED AT THE TIME OF INJURY? YES ? NO ? IF YES, DATE ABLE _____ MO. DAY YR. IF NOT, ANTICIPATED DATE _____ MO. DAY YR.
 ABLE TO DO A LIGHTER OR DIFFERENT TYPE OF WORK THAN PERFORMED AT TIME OF INJURY? YES ? NO ? IF YES, DATE ABLE _____ MO. DAY YR. IF NOT, ANTICIPATED DATE _____

30. REMARKS: _____

NAME OF PHYSICIAN _____ BILLING CODE NO. _____
 ADDRESS _____ ZIP _____ PHONE _____
 IRS NO. _____ PROFESSIONAL CORP? YES ? NO ? _____

DATE OF THIS REPORT _____ MO. DAY YR. _____ PHYSICIAN'S SIGNATURE REQUIRED HERE **X**

Workman Compensation Insurance Carriers

Accentcare

AIG
P.O. Box 32130
Phoenix, AZ 85604
Contact info: Palamanku Betsy
949-623-1510

Bashas

Bashas Risk Management

Attn: Barbara Schroder
P.O. Box 488
Chandler, AZ 85244
Contact info: Audrey Miller
3063
602-594-1187

Wal Mart

ACMI Claims Management
P.O. Box 1288
Bentonville, AR 72712
Contact Info: Adriana Zapata
1-800-599-9906
Claims info to 479-621-2938

City Of Douglas

SCF of Arizona
Contact Info: Nadia
520-805-5507
520-417-7326
4527

Kathy 432-9710

University Of Arizona

State of Arizona Risk Management
WC
100 N 15th Ave., Suite 301
Phoenix AZ 85007
66225
Contact Info: Irma Mendoza
602-542-5231

Subway

Copper Point
Contact Info:
Heidi at Express Stop
602-267-1211 ext 210

DOC

AZ Risk Management

100 N 15th Ave. Suite 301
Phoenix AZ 85007
1-602-542-2182
Unpaid Claims 602-364-

Fax 602-642-1990

Safeway

2750 S Priest
Tempe AZ 85282
480-894-4190
Contact info: Liz
480-894-4190

Arizona Cochise County

Insurance Pool
1905 W Washington #200
Phoenix AZ 85009
Attn: Arlene 602-452-

Contact Cochise County

JC Penney

AIG Domestic Claims for

Po Box 25977
Shawnee Mission, KS

Workman Compensation Insurance Carriers

Vision Quest Trucking

Fair Isaac Corporation
4876
110 Theory
Irvine, CA 92612

Manuel Huertas

Claim Info. Rocio 289-

WC AIG
P.O. Box 25972
Shawn BB
Mission, KS 66225

Arizona Department of Transportation

Risk Management
Attn: Lily Gutierrez
1-602-712-7755

Eurofresh Bonita Nursery

Wausau Insurance
P.O. Box 4025
Beaverton, OR 97076
1-800-424-0054

Douglas Unified School District

Arizona School Alliance
P.O. Box 33037
Phoenix, AZ 85067
602-222-2155
Fax 602-222-2145
Contact: Denise Young
Submit claims with medical record

Kids Outlet

ICM Claims
1150 W State Street, Suite 330
Boise, ID 83702
208-388-8768

Chemical Lime

ESIS Inc.
P.O. Box 31186
Tampa, FL 33631
1-800-542-9937
520-456-9071
Treatment numbers to be obtain from:
Coventry Health Care
1-800-810-4481

Heart Felt Help

Copper Point
P.O. Box 33069
Phoenix, AZ 85067
Claim Contact info: Brenda

Omega Alpha Academy

Copper Point
P.O. Box 33069
Phoenix, AZ 85067

DARC

Copper Point
P.O. Box 33069
Phoenix, AZ 85067

Workman Compensation Insurance Carriers

Dorado Perspnnel

Copper Point
Services
P.O. Box 33069
Phoenix, AZ 85067

US Border Patrol

DFDC Central Mailroom – 13
P.O. Box 8300
London, KY 40742-8300
1-805-558-1818
1-866-335-8319

Cochise College

AIG Domestic Claims
P.O. Box 25971
Shawnee Mission, KS 66225

Sloan Fencing

Pinnacle Risk Management
7500 N Dreamy Draw Drive
Phoenix, AZ 85020

US Customs

WC US Department of Labor
DEFC Central Mailroom 13
London, KY 40742-8300
Claims contact: Willie Herzinger
602-914-1400 ext 222

Catholic Community Services

Gallagher Bassett

P.O. Box 238152
Tucson, AZ 85734

Cochise County

Arizona Risk Management
100 N. 15th Avenue, Suite 301
Phoenix, AZ 85007
Claim issues: Wendy
520-432-9362

La Solano

CNA
333 S Wabash
Chicago, IL 60604
1-877-262-2727

US Forrest Service

ASC-HCM
OWCP Mailstop 113900
Masthead Avenue NE
Albuquerque, NM 87109

Gadsden Hotel

Gallaher Basset
4110 Scottsdale Road, St 370
Scottsdale, AZ 85251
1-480-948-2105
Contact info: David Gray

Workman Compensation Insurance Carriers

Checkers Auto

Zurich American Insurance Co.
1400 American Lane
Schaumburg, IL 60196-1056
Policy Number 3036507wc02

Douglas Dialysis Center

Wausau Company
P.O. Box 4025
Beaverton, OR 97076
1-800-424-0054
Contact info: Selina
1-800-872-0007
Case number required

Fiesta Canning

Nationwide AgriBusiness/Farmland Ins.
1100 Locust Street Dep 3010
Des Moines, IA 50391
1-800-228-6700

Chartwells Group

Cambridge Integrated Services Group Inc.
P.O. Box 2002
Warren, MI 48090-2002

Douglas Meat Market

Copper Point
602-631-2300

Home Depot

Sedgwick CMS Home Depot
P.O. Box 14488
Lexington, KY 40512-4488
Claim number is needed

SEABHS

Cooper Point
520-287-4713 Nogales
928-428-6051 Safford Michelle
Policy number 109219-6

Burger King Douglas

Double D Food Services
480-633-6672
Adjustor: Scoot Woodside
520-495-5332

McDonalds

Copper Point
602-631-2300

Sun Drywall and Stucco

Copper Point
602-631-2300

Medicare A and B Eligibility

NOTICE: This information is classified as individually identifiable healthcare information and is intended strictly for the confidential use of the authorized requestor. Any unauthorized use or disclosure of this information is prohibited.

Member is Eligible

SEARCH CRITERIA

NPI:

Medicare ID:

Last Name:

First Name:

Date of Birth:

Eligibility Coverage Type:

Beginning Plan Date:

SUBSCRIBER

Name:

Member ID Number:

Address:

Date of Birth:

Sex:

Eligibility Date(*)

HEALTH BENEFIT PLAN COVERAGE

Benefit	Insurance Type	Time Period	Amount
Reserve	Medicare Part A	Day	

HEALTH BENEFIT PLAN COVERAGE

Benefit	I	T	Amount	Plan Date
Active Coverage	M			06/01/1999
Deductible	M	E		01/01/2014
Deductible	M	R		01/01/2014 - 12/31/2014
Reserve	M	L	60 Days	
Reserve	M	L	60 Days	
Active Coverage	M			08/01/2000
Deductible	M	C	\$147.00	01/01/2014 - 12/31/2014
Deductible	M	R	\$147.00	01/01/2014 - 12/31/2014
Co-insurance	M	V	20%	01/01/2014 - 12/31/2014

HEALTH BENEFIT PLAN COVERAGE

Eligibility or Benefit Information: Co-Payment

Insurance Type: Medicare Part A

Time Period: Day

Amount: SO-00

Unit Or Basis: Days

Time Period: Remaining

Period Count: 60

Time Period: Episode

Period Count: 1

Benefit Date

Message:

HEALTH BENEFIT PLAN COVERAGE

Eligibility or Benefit Information: Co Payment

Insurance Type: Medicare Part A
Time Period: Day
Amount: \$304.00
Unit or Basis: Days
Time Period: Remaining
Period Count: 30
Time Period: Episode
Period Count: 1
Benefit Date: 01/01/2014 - 12/31/2014
Message: 30 REMAINING COPAY DAYS FOR THE BENEFIT PERIOD.

HEALTH BENEFIT PLAN COVERAGE

Eligibility or Benefit Information: Other or Additional Payer

Insurance Type: HMO - Medicare Risk HN
Primary Payer Name: ARIZONA PHYSICIANS IPA, INC
Address: 1 East Washington
 Suite 900
 Phoenix, AZ 85004
Telephone: (888) 903-7587
URL: www.UHCCommunityPlan
Plan Number:
Coordination of Benefits Date: 03/01/2013
Message: MCO BILL OPTION CODE C

OSPITAL - INPATIENT

Benefit	Insurance Type	Plan Date
	Active Coverage Medicare Part A	06/01/1999
HOSPITAL - ROOM AND BOARD		
Benefit	Insurance Type	Plan Date
Active Coverage	Medicare Part A	06/01/1999

PHARMACY

Eligibility
Insurance Type: Other
Payer Name: ARIZONA PHYSICIANS IPA, INC.
Address: 1 East Washington
 Suite 900
 Phoenix, AZ 85004
Telephone: (888) 903-7587
Plan Number:
Benefit Date: 03/01/2013

Passport Reference Number:



https://onesource.passporthealth.com/_rners/RR 1.11/OneSoureeM in i
Response/Response... 7/11/2014