CREDIT AND COLLECTION POLICY

Revised: December 23, 2004; September 28, 2005; September 28, 2008; December 16, 2008; February 26, 2010; May 9, 2011, August 31, 2011

LOWELL GENERAL HOSPITAL
CREDIT AND COLLECTION POLICY

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LOWELL GENERAL HOSPITAL
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I. INTRODUCTION

PURPOSE

The hospital is the frontline caregiver providing medically necessary care for all people regardless of ability to pay. The hospital offers this care for ***all*** patients that come to our facility 24 hours a day, seven days a week, and 365 days a year.

The hospital assists patients in obtaining financial assistance from public programs and other sources whenever appropriate. To remain viable as it fulfills its mission, the hospital must meet its fiduciary responsibility to appropriately bill and collect for medical services provided to patients. This credit and collection policy is designed to comply with state and federal law and regulations in performing this function. The hospital does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual preference, age, or disability in its policies or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pre-treatment deposits, payment plans, deferred or rejected admissions, Low Income Patient status as determined by the Massachusetts Office of Medicaid, determination that a patient is low-income, or in its billing and collection practices.

It is important to note that while the federal and state government uses different names for the policies that hospital must follow to show how they are providing financial assistance to patients; the overall requirements are the same. As a result, this policy is designed to comply with both the state Health Safety Net regulations on "Credit and Collection Policies" and the federal HealthCare Reform Law's "Financial Assistance Policy" requirements as recently clarified by the Internal Revenue Service in their February 23, 2011 instructions to the Form 990.

These credit and collection policies are developed to ensure compliance with applicable criteria required under (1) the Health Safety Net Eligibility Regulation (114.6 CMR 13.00), (2) the Centers for Medicare and Medicaid Services Medicare Bad Debt Requirements (42 CFR 413.89), (3) The Medicare Provider Reimbursement Manual (Part 1, Chapter 3), and (4) the Internal Revenue Code Section 501(r) as required under the Section 9007(a) of the federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and as recently clarified in the February 28, 2011 IRS clarification to reporting such information in the hospital IRS 990 returns.

LOWELL GENERAL HOSPITAL MISSION

"Patients First In Everything We Do"

- We are sensitive and responsive to the individual needs of our patients and their family members.
- We are committed to providing quality care to our patients through a highly trained and motivated staff, state-of-the-art equipment, progressive clinical care, and collaborative teamwork.
- We continuously evaluate and improve services to meet the needs of our patients and the community we serve.
- We go the extra mile to serve our customers with kindness, compassion, and respect.

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GENERAL PRINCIPLES

Lowell General Hospital follows the following basic tenets when working with patients regarding their financial obligations:

- Fear of a hospital bill should never get in the way of patients receiving essential health services. Lowell General Hospital will communicate with patients regarding their ability to access medically necessary care and the availability of financial assistance.

- The hospital has financial aid policies that are consistent with the mission and values of the organization and take into account each individual's ability to contribute to the cost of his or her care and the hospital's financial ability to provide the care. These policies are communicated in a clear and easy to understand manner.

- Debt collections policies for both hospital staff and external collections agencies reflect the mission and values of the hospital.

- Financial assistance provided by the hospital is not a substitute for the responsibility of government and employers to find solutions to expand access to health care coverage of all Massachusetts residents.

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II. DELIVERY OF HEALTHCARE SERVICES

The hospital evaluates the delivery of health care services for all patients who present for services regardless of their ability to pay. However, non-emergent or non-urgent health care services (i.e., elective or primary care services) may be delayed or deferred based on the consultation with the hospital's clinical staff and, if necessary and, if available, the patient's primary care provider. The hospital may decline to provide a patient with non-emergent, non-urgent services in those cases when the Hospital is unable to identify a payment source or eligibility in a financial assistance program. Such programs include MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Health Safety Net, and others. Choices related to the delivery and access to care is often defined in either the insurance carrier's or the financial assistance program's coverage manual.

The urgency of treatment associated with each patient's presenting clinical symptoms will be determined by a medical professional as determined by local standards of practice, national and state clinical standards of care, and the hospital medical staff policies and procedures. Further, all hospitals follow the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requirements by conducting a medical screening examination to determine whether an emergency medical condition exists. 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 evaluation of the patient's medical condition reflected in final diagnosis.

For those patients that are uninsured or underinsured, the hospital will work with patients to assist with finding a financial assistance program that may cover some or all of their unpaid hospital bill(s). For those patients with private insurance, the hospital must work through the patient and the insurer to determine what may be covered under the patient's insurance policy. As the hospital is often not able to get this information from the insurer in a timely manner, it is the patient's obligation to know what services will be covered prior to seeking non-emergency level and non-urgent care services. Determination of treatment based on medical conditions is made according to the following definitions:

A. Emergency and Urgent Care Services

Any patient who comes to the Hospital will be evaluated as to the level of emergency level or urgent care services without regard to the patient's identification, insurance coverage, or ability to pay. The evaluation of emergency level or urgent care services as defined below is further used by the Hospital for purposes of determining emergency and urgent bad debt coverage under the Health Safety Net Fund.

a. Emergency Level Services includes:
   i. 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)(1)(B). A medical screening examination and any subsequent treatment for an existing emergency medical conditions 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.

b. Urgent Care Services include:
   i. Medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient

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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.

c. EMTALA Level Requirements:

i. 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 patient's who either (1) arrive to the hospital seeking non-emergent or non-urgent level care or (2) seek additional care following stabilization of an emergency medical condition, the hospital may provide elective services after consulting with the hospital's clinical staff and reviewing the patient's coverage options.

a. Elective Services: Medically necessary services that do not meet the definition of Emergent or Urgent 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).

C. Locations where patients may present:

All patients are able to seek emergency level services and urgent care services when they come to the hospital emergency department or designated urgent care areas. However, patients with emergent and urgent conditions may also present in a variety of other locations, including but not limited to Labor and Delivery, ancillary departments, hospital clinics and other areas. The hospital also provides other elective services at the main hospital, clinics and other outpatient locations.

III. DOCUMENTING ELIGIBILITY FOR FINANCIAL ASSISTANCE PROGRAMS

A. General Principles

Financial assistance is intended to assist low-income patients who do not otherwise have the ability to pay for their health care services. Such assistance takes into account each individual's ability to contribute to the cost of his or her care. For those patients that are uninsured or underinsured, the hospital will work with them to assist with applying for available financial assistance programs that may cover all or some of their unpaid hospital bills. The Hospital provides this assistance for both residents and non-residents of Massachusetts; however, there may not be coverage in a state public assistance program for a Massachusetts hospital's services for an out-of state resident. In order for the hospital to assist uninsured and underinsured patients find the most appropriate coverage options as well as determine if the patient is financially eligible for any discounts in payments, patients must actively work with hospitals to verify the patient's family income, other insurance coverage, and any other information that could be used in determining eligibility.

B. Hospital Screening and Eligibility Approval Process

The hospital provides patients with information about financial assistance programs that are available through the Commonwealth of Massachusetts or through the hospital's own financial assistance program, which may cover all or some of their unpaid hospital bill. For those patients that request such assistance, the hospital assists patients by screening them for eligibility in an available public program and assisting them in applying for the program. These programs include, but are not limited to: MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Health Safety Net, and others. When applicable, the hospital may also assist patients in applying for coverage of services as a Medical Hardship based on the patient's documented family income, current and prior insurance coverage, and allowable medical expenses.

It is the patient's obligation to provide the hospital with accurate and timely information regarding their full name, address, telephone number, date of birth, social security number (if available), current and prior health insurance coverage options (including any other insurance or coverage options (like a motor vehicle policy or worker's compensation policy) that can cover the cost of the care received), any other applicable financial resources, and citizenship and residency information. This information will be used to determine coverage for the services provided to the patient. If there is no specific coverage for the services provided, the hospital will use the information to determine if the services may be covered by an applicable program that will cover certain services deemed bad debt. In addition, the hospital will use this information to discuss eligibility for certain health insurance programs. If the patient or guarantor is unable to provide the necessary information, the hospital may (at the patient's request) make reasonable efforts to obtain any additional information from other sources. This will occur when the patient is scheduling their services, during pre-registration, while the patient is admitted in the hospital, upon discharge, or for a reasonable time following discharge from the hospital. Information that the hospital obtains will be maintained in accordance with applicable federal and state privacy and security laws.

The screening and application process for a public health insurance programs is done through either the Virtual Gateway (which is an internet portal designed by the Massachusetts Executive Office of Health and Human Services to provide the general public, medical providers, and community-based organizations with an online application for the programs offered by the state) or through a standard paper application that is completed by the patient and also submitted directly to the Massachusetts Executive Office of Health and Human Services for processing. The Massachusetts Executive Office of Health and Human Services solely manages the application process for the programs listed above, which is available for children, adults, seniors, veterans, homeless, and disabled individuals.

In special circumstances, the hospital may apply for the patient using a specific form designed by the Massachusetts Division of Health Care Finance and Policy. Special circumstances include individuals seeking financial assistance coverage due to being incarcerated, victims of spousal abuse, or applying due to a Medical Hardship.

The hospital specifically assists the patient in completing the Massachusetts Executive Office of Health and Human Services standard application and securing the necessary documentation required by the applicable financial assistance program. Necessary documentation includes proof of: (1) annual household income (payroll stubs, record of social security payments, and a letter from the employer, tax returns, or bank statements), (2) citizenship and identity, (3) immigration status for non-citizens (if applicable), and (4) assets of those individuals who are also enrolled in the Medicare program. The hospital will then submit this documentation to the Massachusetts Office of Medicaid and assist the patient in securing any additional documentation if such is requested by the state after completing the application. Massachusetts places a three day time limitation on submitting all necessary documentation following the submission of the application for a program. Following this three day period, the patient and the provider must work with the MassHealth Enrollment Centers to secure the additional documentation needed for enrollment in the applicable financial assistance program.

All Virtual Gateway and paper applications are reviewed and processed by the Massachusetts Office of Medicaid, which uses the Federal Poverty Guidelines, asset information, as well as the necessary documentation listed above as the basis for determining eligibility for state sponsored public assistance programs. The eligibility for enrollment into the Health Safety Net program for full or partial Health Safety Net coverage is also determined through the Virtual Gateway. The hospital will also assist other patients, such as minors receiving confidential services or individuals who have been battered or abused, obtain coverage through the Health Safety Net by using the Massachusetts Division of Health Care Finance and Policy Special Circumstance Application. A copy of the federal poverty guidelines that are used by the state is attached to this policy.

Hospitals have no role in the determination of program eligibility made by the state, but at the patient's request may take a direct role in appealing or seeking information related to the coverage decisions. It is still the patient's responsibility to inform the hospital of all coverage decisions made by the state to ensure accurate and timely adjudication of all hospital bills.

C. Future Programs

As future coverage options are developed by the Commonwealth or federal government, that are in addition to or that amend the programs listed above, Massachusetts hospitals will evaluate their availability for its patients and also include those within the list of programs that are discussed with patients.

IV. NOTICE OF AVAILABILITY OF FINANCIAL ASSISTANCE AND OTHER COVERAGE OPTIONS

1) General Principles:

For those patients who are uninsured or underinsured, the hospital will work with them to assist with applying for available financial assistance programs that may cover some or all of their unpaid hospital bills. In order to help uninsured and underinsured patients find available and appropriate financial assistance programs, the hospital will provide all patients with a general notice of the availability of programs in both the bills that are sent to patients as well as in general notices that are posted throughout the hospital.

The goal of these notices is to assist patients in applying for coverage within a financial assistance program, such as MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Health Safety Net, or Medical Hardship through the Health Safety Net. The hospital will provide, upon request, specific information about the eligibility process to be a Low Income Patient under either the Massachusetts Health Safety Net Program or additional assistance for patients who are low income through the hospital's own internal financial assistance program. The hospital will also notify the patient about available payment plans that may be available to them based on their family size and income.

2) Role of Hospital Patient Financial Counselors and Other Finance Staff

The hospital will try to identify available coverage options for patients who may be uninsured or underinsured with their current insurance program when the patient is scheduling their services, while the patient is in the hospital, upon discharge, and for a reasonable time following discharge from the hospital. The hospital Patient Access Staff will direct all patients seeking available coverage options or financial assistance to the hospital's patient financial counseling office to determine if they are eligible and then to screen for eligibility in an appropriate coverage option. The hospital will then assist the patient in applying for the appropriate coverage options that are available or notify them of the availability of financial assistance through the hospital's own internal financial assistance program.

The hospital will also provide information on how to contact the appropriate staff within the hospital's finance office to verify the accuracy of the hospital bill or to dispute certain charges.

3) Notification Practices:

The hospital will post signage with a notice of availability of financial assistance as outlined in this credit and collection policy in the following locations:

i. Inpatient, clinic, and emergency department and/or waiting areas;
ii. Patient financial counselor areas;
iii. Central admission/registration areas; and
iv. Business office areas that is open to patients.

Posted signs will be large enough to be clearly visible and legible to patients visiting these areas. The wording will notify the patient or visitor of the availability of financial assistance at the hospital. The hospital will also include a notice about the availability of financial assistance in all initial bills.

When the patient contacts the hospital, the hospital finance staff will notify the patient if they may qualify for a payment plan. A patient who is enrolled in a public financial assistance program (e.g., MassHealth, Health Safety Net, or for Medical Hardship) may qualify for certain plans. Patients may also qualify for additional assistance based on the hospital's own internal criteria for financial assistance.

For cases where the hospital is using the Virtual Gateway application, the hospital will assist

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the patient in completing the application for MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Health Safety Net, or other forms of financial assistance programs as they become part of the Virtual Gateway program.

All signs and notices shall be translated into languages other than English if such language is spoken by 10% or more of the population residing in the hospital service area. Currently, the hospital translates the notices into the following languages – Spanish, Portuguese, and Khmer.

V. ACQUISITION OF PATIENT INFORMATION

The hospital, using diligent effort, has a fiduciary duty to seek reimbursement for services it has provided from individuals who are able to pay, from third party insurers who cover the cost of care, and from other programs of assistance for which the patient is eligible. To determine whether a patient is able to pay for the services provided as well as to assist the patient in finding alternative coverage options if they are uninsured or underinsured, the hospital follows the following criteria related to billing and collecting from patients.

A. Collecting Information on Patient Financial Resources and Insurance Coverage

a) Patient Obligations:

Prior to the delivery of any health care services (except for cases that are an emergency or urgent care service level), 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 will include:

1) Full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, citizenship and 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
3) 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, student insurance policies, and any other family income such as an inheritances, gifts, or distributions from an available trust, 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 their current health insurer (if they have one) or the agency that determined the patient's eligibility status in a public program of any changes in family income or insurance status. The hospital may also assist the patient with updating their eligibility in a public program when there are any changes in Family Income or insurance status, but only if the hospital is made aware by the patient of facts that may indicate a change in the patient's eligibility status.

Patients are required to notify the applicable public program in which they are enrolled (e.g., Office of Medicaid and the Health Safety Net), of any information related to a change in family income or any lawsuit or insurance claim that may cover the cost of the services provided by the hospital. A patient is further required to assign the right to a third party payment that will cover the costs of the services paid by the applicable public program, such as the Office of Medicaid or the Health Safety Net. The patient must notify the Health Safety Net Office or MassHealth in writing within 10 days of filing any claim, civil action, or other proceeding.

b) Hospital Obligations:

The hospital will make all reasonable efforts to collect the patient insurance status and other information to verify coverage for the health care services to be provided by the hospital. For many patients coverage determinations is made by either asking for a copy of the patient's

insurance card or checking the MassHealth Eligibility Verification System (EVS) for coverage under an applicable public program. All 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 credit and collection policy). The hospital 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.

The hospital's reasonable and diligent efforts will include, but is not limited to, requesting information about the patient's insurance status, checking any available public or private insurance databases, and following the billings rules of a known third party payer. When hospital registration or admission staff are made aware of any such information, they shall also inform patients of their responsibility to inform the appropriate public program of any changes to family income or insurance status, including any lawsuit or insurance claim that may cover the cost of the services provided by the hospital.

The Admitting/Outpatient Registration department is responsible to gather and verify all patient demographic and health insurance information during the pre-registration process or at the time of registration. Elective or scheduled procedures that are pre-booked are handled by the Admitting or Pre Registration department. The hospital complies with the insurer's billing and authorization requirements and requirements for notifications of admission.

Urgent or Emergent patients that are treated as an Inpatient, Observation or Surgical Service will have third party payer information verified by the Admitting Department. In an emergency or after hours situation if insufficient information is gathered, a Benefit Representative or Patient Financial Counselor will attempt to obtain all necessary information prior to or at time of discharge. All visits to a patient's room will be coordinated and approved by the nursing staff before attempting to interview a patient.

If the patient or guarantor/guardian is unable to provide the information needed, and the patient consents, the hospital will make reasonable efforts to contact relatives, friends, guarantor/guardian, and/or other appropriate third parties for additional information. This may occur when the patient is scheduling their services, during pre-registration, while the patient is admitted in the hospital, upon discharge, or for a reasonable time following discharge from the hospital.

The hospital will also make reasonable and diligent efforts to investigate whether a third party payer 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 policies, (3) worker's compensation programs, (4) student insurance policies, among others. In accordance with applicable state laws or the insurance contract, for any claims where the hospital's reasonable and diligent efforts resulted in a payment from a private insurer or public program, the hospital will report the payment and offset it against any claim that may have been paid by the private insurer or public program. For state public assistance programs, the hospital is not required to secure assignment on a patient's right to a third party coverage on services provided due to an accident. In these cases the State of Massachusetts will attempt to seek assignment on the costs of the services provided to the patient and which was paid for by either the Office of Medicaid or the Health Safety Net.

The hospital maintains all information in accordance with applicable federal and state privacy, security, and ID Theft laws.

VI. HOSPITAL BILLING PRACTICES

Lowell General Hospital administers billing practices and diligent efforts that are efficient and effective in order to secure reimbursement. Accounts are billed timely and accurately following third party regulations.

Before a bill is sent to the payer, it is checked for accuracy of demographics, codes, identification numbers, dates of service matching charges, and reasonableness of charges.

Claims for covered services are submitted electronically or manually as soon as possible after discharge or date of service. Accounts are updated with notations from the electronic or manual submission file.

A. LATE CHARGES

Charges are to be considered late when charges are received after the initial billing. These charges will be processed according to the Late Charge Billing Procedure.

B. BILLING FOLLOW UP

The Patient Accounting Department will make all reasonable efforts to collect amounts owed and resolve issues with third party payers. All action taken will be notated on account screens: to include date, name and telephone number of person spoken to and any action taken or required.

Follow up time frame criteria is used for the system's automatic message to the staff indicating which accounts need follow up. These ticklers are generated during system close and are in the staff's queue that morning. Open accounts reports are routinely run and reviewed by the staff and management.

C. REJECTIONS

Rejections should be completed within a week of receipt. The reject advices are coded and keyed on the account. The account is then analyzed. Other listed coverage is billed when appropriate. If the reject is correct and no other coverage is listed the account is made a self-pay. If the reject is incorrect or questionable, the A/R Representative follows up online, via the phone, or via memo with appropriate documentation.

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VII. ACCOUNTS RECEIVABLE

A. CREDIT BALANCES

Inpatient and Outpatient credit balances are worked from the monthly credit balance report. The accounts are analyzed and processed either by (1) an adjustment, (2) a third party notification for retractions or COB, (3) a refund or (4) a transfer.

Current credit aged trial balances are run and worked biweekly.

B. PATIENT REFUND PROCEDURE

Over-payments or incorrect payments received by the hospital will be refunded on a timely basis. The process provides an audit trial and internal control of all refund checks issued. If the patient has other outstanding balances on other accounts, the refund will be applied against the other open account. Medicare patients will a self-pay credit balance will be contacted to check their preference for either a refund or a transfer of funds between open accounts for any self pay balances.

C. RETURNED PATIENT REFUND PROCEDURE

If after utilizing normal procedures to determine the appropriate address of the patient it still can not be determined, checks that cannot be delivered will be notated and become part of the abandoned property procedure.

If a refund check is returned from a third party, the refund is to be researched and resolved.

If the third party deems the refund belongs to the patient, the Accounts Receivable Analyst is to attach the notice to the account and void the check. The Accounts Receivable Analyst will follow the "Patient Refund" policy at this point. The Accounts Receivable Analyst will also reverse the code showing a refund was issued thus creating a new credit.

D. AUDITS

Third party audits are handled as received by the Health Information Management Department. Accounts are printed and appropriate data is provided. Accounts Receivable follows through on their designated audits and passes the information on to other areas when applicable.

E. THIRD PARY INVOICES

Third party invoices are processed as received. They are reviewed and appealed if necessary.

F. SMALL BALANCES

Small balance accounts (-$9.99 through $9.99) are automatically adjusted by the system as a hospital write-off. Small balance write-offs will not be billed to the pool.

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HOSPITAL COLLECTION PRACTICES

A. GENERAL INFORMATION

The hospital will strive to maximize third party reimbursement at all times. However, when the third party coverage fails to cover the services rendered in full or no third party coverage is in effect, we must look to the patient or the patient's representative to pay.

All known patient portions are payable in full at the time services are rendered, unless the patient qualifies for Public Assistance or requires emergency services. Patients who qualify for public assistance or who service is coded emergent are not required to make payments in full at the time services are rendered. If a patient is unable to pay the full balance, the hospital may make financial arrangements with the patient. The hospital offers a payment plan option providing for installment payments of the patient's bill.

When a patient (or patient representative) presents to make financial arrangements because they are not insured or are underinsured, the Benefit Representative, in accordance with hospital policy and procedure, will handle arrangements. The Benefit Representative will attempt set up a payment arrangement with the patient, or if appropriate will direct the patient to a Patient Financial Counselor who will start the Public Assistance procedure at this time if the patient appears to be eligible or assist with any other applicable public assistance.

If the patient is ineligible or chooses not to seek this type of assistance, the Benefit Representative will make the appropriate financial arrangements as defined in the Payment Plan section below.

If the patient does not make financial arrangements, is not eligible or defaults on the arrangements, the collection routine will be followed as outlined in the Self Pay Policy below.

Prior to treatment, the hospital will make reasonable efforts to obtain the necessary information to determine responsibility for payment of hospital outpatient services. This information will be collected by direct contact with the patient, guarantor or the physician's office requesting the service. No patient will be denied emergency treatment. If a patient is seeking a service on an elective basis and a financial arrangement cannot be agreed before the service is rendered, that service may be delayed until appropriate arrangements are made. The decision that a service is medically necessary and must be rendered will be determined by the attending physician.

When the collection routine has been followed and the self-pay balance remains unpaid, the Patient Financial Service Manager will assign the account to bad debt status in accordance with hospital policy and procedure. The hospital will strive to assign all accounts within 180 days from the self-pay liability, but not less than 120 days from the date of service.

All self-pay balances will be dunned at least every 30 days. The messages on the data statement will clearly note the amount due.

All collection activity will be noted on the patient accounts. These notes will reflect dates, including years, action taken, by whom, with whom, results of any action, and any other pertinent information. The system will record who made the notes entry.

B. SELF-PAY

When a balance is owed by the patient, payment in full is always requested. The following is the

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collection routine to be followed on all self-pay account balances.

1) The account will be forwarded to the contracted billing company to follow the collection process.

   a. Account will automatically be referred to the contracted billing company upon reaching final bill status or self pay accounts after third party payment. This initial bill will be sent to the patient or the party responsible for the patient's personal financial obligations. All mailings will advise the patient that Financial Assistance is Available and that a Financial Counselor can be contacted.

   b. Mailings will be sent on a 30 day incremental cycle/four statement cycle or until the balance is resolved. Follow-up phone calls will be made.

   c. Any subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, or any other notification method constitutes a genuine effort to contact the party responsible for the obligation in an effort to resolve outstanding balances. The responsible party will be informed of the availability of financial assistance.

   d. If the patient statement is returned as incorrect address or undeliverable, attempts are made to find a better address by using one or more of the following resources. Review other open accounts for a better address. Calling the patient or using skip tracing on bad phone numbers. Using Internet sources for new addresses or phone numbers.

   e. Sending a final notice by certified mail for uninsured patients (those who are not enrolled in a public program such as the Health Safety Net or MassHealth) who incur an emergency bad debt balance over $1,000 on Emergency Level Services only, where notices have not been returned as "incorrect address" or "undeliverable." Such notices will advise the patients of the availability of financial assistance in the communication;

   f. All such efforts to collect balances, as well as any patient initiated inquiries, will be documented in the computer billing system and available for review.

   g. Documentation of continuous billing or collection action undertaken on a regular, frequent basis is maintained. 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. The federal Medicare program and the state Division of Health Care Finance and Policy for purposes of the Health Safety Net Program, deems 120 days as appropriate for continuous billing or collection actions.

   h. Checking the Massachusetts Eligibility Verification System (EVS) to ensure that the patient is not a Low Income Patient as determined by the Office of Medicaid and has not submitted an application to the Virtual Gateway system for coverage of the services under a public program, prior to submitting claims to the Health Safety Net Office for emergency bad debt coverage of an emergency level or urgent care service.

   i. If not paid at the end of 120 days, the "Bad Debt Procedure" will be followed.

2) Accounts involving third party litigation that require intervention by our collection attorneys may be assigned to bad debt status and referred for follow-up. The Patient Financial Services

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Manager or Chief Financial Officer will approve these accounts for bad debt based on the expected length of time to recover our payment and the need for legal counsel.

3) All collection agencies working on behalf of Lowell General Hospital will commit in writing to abide by collection practices and standards approved by Lowell General Hospital.

C. OUTSIDE COLLECTION AGENCIES

The hospital contracts with an outside collection agency to assist in the collection of certain accounts, including patient responsible amounts not resolved after issuance of hospital bills or final notices. However, as determined through this credit and collection policy, the hospital may assign such debt as bad debt or charity care (otherwise deemed as uncollectible) prior to 120 days if it is able to determine that the patient was unable to pay following the hospital's own internal financial assistance program.

The hospital has a specific authorization or contract with the outside collection agency and requires such agencies to abide by the hospital's credit and collection policies for those debts that the agency is pursuing, including the obligation to refrain from "extraordinary collection activities" until such time as the hospital has made a reasonable effort and followed a reasonable process for determining that a patient is entitled to assistance or exemption from any collection or billing procedures under this credit and collection policy. All outside collection agencies hired by the hospital will provide the patient with an opportunity to file a grievance and will forward to the hospital the results of such patient grievances. The hospital requires that any outside collection agency that it uses is licensed by the Commonwealth of Massachusetts and that the outside collection agency also is in compliance with the Massachusetts Attorney General's Debt Collection Regulations at 940 C.M.R. 7.00.

D. HOSPITAL SUPPLEMENTAL FINANCIAL ASSISTANCE PROGRAM

LGH offers financial assistance to qualifying patients to assist with certain self-pay obligations for medically necessary services not covered by third party payers and for copayments, deductibles or coinsurance on covered services. The Hospital Supplemental Financial Assistance Program is meant to supplement – and not replace - other coverage for services in order to ensure the financial assistance is provided where most needed. Patients eligible for health coverage through their (or a family member's) employer or State Programs will not be eligible for the Hospital Supplemental Financial Assistance Program. Financial assistance from the Hospital Supplemental Financial Assistance Program cannot be combined with any Prompt Payment Discounts, if provided.

1. <u>Hospital Supplemental Financial Assistance Program Eligible Patients</u>

The following patients will be considered qualifying patients and will be eligible for this financial assistance to the extent described below:

(a) Self pay patients with no insurance, that do not qualify for State Programs or the Health Safety Net; or

(b) Patients who qualify for State Programs or Health Safety Net but have received medically necessary services prior to effective coverage date

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or have received medically necessary services ineligible for coverage; or

(c) Patients who qualify for partial free care but seek assistance with a partial free care deductible; or

(d) Patients who qualify for full or partial free care but have received Medically Necessary services ineligible for State Programs, free care, other governmental programs or private insurance; or

(e) Patients who are enrolled in State Programs in which the Hospital is not enrolled as a provider and therefore cannot obtain payment; or

(f) Patients who are deceased and have no estate will be given individual consideration; or

(g) Patients who are bankrupt will be given individual consideration; or

(h) Patients who meet Health Safety Net income criteria for Medical Hardship and have balances (after free care) of $10,000 or more. Specifically, these patients may (1) be eligible for Medical Hardship assistance under the Health Safety Net but have patient contribution requirements greater than $10,000 or (2) meet the Medical Hardship income criteria, but are ineligible for free care because the services received are not hospital-licensed services. In such circumstances:

(i) Financial assistance will be determined after a review of all financial information and circumstances.

(ii) Financial assistance will generally reduce an outstanding balance to 15% of annual income absent significant assets.

(iii) Financial assistance up to 100% will be considered based on the patient's particular medical and financial circumstances and must be approved by the LGH Vice President of Finance/CFO or his/her designee.

Non-U.S. citizens will be eligible to extent required by law and must be considered on a case by case basis based on their financial situation as additional investigation may be required to determine and assess their insurance coverage and financial circumstances.

2. <u>Eligibility Period</u>

If a patient is determined to be eligible for financial assistance under the Hospital Supplemental Financial Assistance Program, the determination will apply to all outstanding balances due to the hospital (including accounts referred to collection agencies) for Medically Necessary services covered by the financial assistance.

The determination that a patient is eligible for financial assistance under the Hospital Supplemental Financial Assistance Program will be effective for one year from the date of determination, unless over the course of that year the patient's family income or

insurance status changes to such an extent that the patient becomes ineligible. Patients will be expected to update their financial information in the event of a change.

3. Level of Financial Assistance

Patients who qualify for the Hospital Supplemental Financial Assistance Program will be eligible for financial assistance to the extent described below.

Financial assistance is available to qualifying patients for outstanding charges for medically necessary services not covered by the State Programs, the Health Safety Net or other third parties based on income levels.

Financial assistance is available to patients for outstanding deductibles, co-payments or co-insurance based on income levels.

Supplemental Financial Assistance Program

Income as a percentage of Federal Poverty Income Guidelines	LGH Financial Assistance for "Non-covered" medically necessary service	LGH Financial Assistance for co-pays or deductibles*
0%-200%	100%	100%
201%-400%	Payments due after application of financial assistance will not exceed amounts equal to Medicare rates	none

* per inpatient admission or outpatient episode of care

E. PROMPT PAYMENT DISCOUNTS

All patients with account balances in excess of $500 (other than balances resulting from co-payments or deductibles on insured services) are eligible to receive a prompt pay discount of 20% of the balance for claims paid in full within 60 days of the date of the initial bill. Patients must request the discount. The discount cannot be combined with Hospital Supplemental Financial Assistance Program.

F. GENERAL OVERVIEW OF COLLECTION ACTIONS

The hospital will not undertake any "extraordinary collection activities" until such time as the hospital has made a reasonable effort and followed a reasonable review of the patient's financial status, which will determine that a patient is entitled to financial assistance or exemption from any collection or billing activities under this credit and collection policy. The hospital will keep any and all documentation that was used in this determination pursuant to the hospital's applicable record retention policy. Extraordinary collection activities may include lawsuits, liens on residences, arrests, body attachments, or as otherwise described below in compliance with state requirements.

G. INTEREST

Lowell General Hospital will not apply interest charges on overdue accounts.

H. CREDIT RATING SERVICES

Neither Lowell General Hospital, nor its contracted collection agencies, will make any report to a credit rating service for unpaid medical bills.

I. LIENS

An agent acting on the behalf of Lowell General Hospital may not place a lien and/or an attachment without the written approval of the hospital.

If the hospital or its agency is forced to place a lien and/or an attachment on either the personal residence or the personal automobile of a patient the following guidelines will be instituted:

1) The Finance Committee of the Board of Trustees must approve the action.

2) Said liens will not be executed against a patient whose income is less than or equal to 200% of the Federal Income Poverty Guidelines.

3) The Finance Committee of the Board of Trustees must approve each execution of a lien against the residence or car of any patient.

4) The hospital will not force the sale or foreclosure of a patient's primary residence to pay an outstanding bill.

5) The hospital will not use body attachment to require the patient or responsible party to appear in court.

6) Lowell General Hospital will not garnish wages to obtain payment on delinquent accounts without the authorization of the Finance Committee of the Board of Trustees.

J. BAD DEBT PROCEDURE

Emergency Bad Debt medically necessary services will be submitted if the following conditions are met:

1. The services were provided to an uninsured patient that has not been determined to be a Low Income patient and the EVS system is checked to determine if the patient has filed an application for MassHealth or the uninsured patient is assisted by LGH in completing a MassHealth application and is determined to be a Low Income Patient or determined into a category exempt from collection action in accordance with regulation.
2. The services resulted from an emergency visit, including any ancillary services and any charges for an inpatient or observation stay.
3. The services provided were of an emergency nature and the hospital followed the Collection Action as required by state regulation.
4. The bill remains unpaid after a period of 120 days.

The hospital will assign accounts, when appropriate, to either a collection agency or a law firm for further collection action if the account balance warrants such action. The decision of which type of agent to assign to an account to will be made by the Patient Financial Service Manager.

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A listing of all accounts written off to Bad Debt will be maintained by the Patient Financial Service Manager, by month, within fiscal years. A clear audit trail will be kept so all actions taken to collect the debt will be noted.

The Hospital will submit all eligible emergency Bad Debts according to 114.6 CMR 13.06(2).

K. EXEMPTION FROM SELF PAY BILLING AND COLLECTION ACTIVITIES

The following individuals and patient populations are exempt from any collection or billing procedures beyond the initial bill pursuant to state regulations:

1) PUBLIC HEALTH PROGRAMS

(a) Patients enrolled in a public health insurance program, including but not limited to, MassHealth, Emergency Aid to the Elderly, Disabled and Children, Healthy Start, Children's Medical Security Plan, "Low Income Patients" as determined by the Office of Medicaid – subject to the following:

(i) The hospital 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.

ii) The hospital may also initiate billing or collection for a patient who alleges that he or she is a participant in a financial assistance program that covers the costs of the hospital services, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in a financial assistance program, (including receipt or verification of signed application) the hospital shall cease its billing or collection activities.

iii) The hospital may continue collection action on any Low Income Patient for services rendered prior to the Low Income Patient determination, provided that the current Low Income Patient status has been terminated or expired. However, once a patient is determined eligible and enrolled in the Health Safety Net, MassHealth, or certain Commonwealth Care programs, the hospital will cease collection activity for services provided prior to the beginning of their eligibility.

iv) The hospitals may seek collection action against any of the patients participating in the programs listed above for non-covered services that the patient has agreed to be responsible for, provided that the hospital obtained the patient's prior written consent to be billed for the service.

v) The hospital will not undertake collection action against an individual that has been approved for Medical Hardship under the Massachusetts Health Safety Net program with respect to the amount of the bill that exceeds the Medical Hardship contribution. If a claim already submitted as Emergency Bad Debt becomes eligible for Medical Hardship payment from the Health Safety Net, the hospital must ceases collection activity on the patient for the services.

(b) The hospital will not garnish a Low Income Patient's (as determined by the Office of Medicaid) or their guarantor's wages or execute a lien on the Low Income

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Patient's or their guarantor's personal residence or motor vehicle unless: (1) the hospital can show the patient or their guarantor has the ability to pay, (2) the patient/guarantor did not respond to hospital requests for information or the patient/guarantor refused to cooperate with the hospital to seek an available financial assistance program, or (3) for purposes of the lien, it was approved by the hospital's Board of Trustees on an individual case by case basis.

(c) The hospital may bill Low Income Patients for services other than Eligible Services provided at the request of the patient and for which the patient has agreed to be responsible. The hospital will obtain the patient's written consent in advance. The following are exceptions the will not be billed to Low Income Patients:

i) Claims related to medical errors including services directly related to a Serious Reportable Event (SRE) as defined in 105 CMR 130.332(A).

ii) Claims denied by the patient's primary insurer due to an administrative or billing error.

2) BANKRUPTCY

The hospital and its agents shall not continue collection or billing on a patient who is a member of a bankruptcy proceeding except to secure its rights as a creditor in the appropriate order, provided that the state of Massachusetts will file its own recovery action for those patients enrolled in MassHealth or the Health Safety Net.

When the hospital receives legal notice a patient (or guarantor) is filing for bankruptcy, the following procedure will be instituted by the Patient Financial Counselor.

1) All action should take place as soon as possible after receipt of the notice.

2) The legal notice is to be date stamped and initialed. Whenever possible, the envelope is to be retained with the notice.

3) Credit is to check the A/R system and the Bad Debt listings from the agencies to find all accounts that are affected by the notice. Open accounts are to be noted with the date and fact a bankruptcy is being filed. A copy of the bankruptcy notice will be attached to an adjustment sheet and the account is to be written off to Bad Debt manual. If an agency is involved, they should be immediately notified.

L. ELIGIBLE CLAIMS TO THE HEALTH SAFETY NET OFFICE

In compliance with the DHCFP regulations, Lowell General Hospital will submit the following eligible services for payment from the Health Safety Net Office.

1) Eligible services provided to Low Income Patients approved for Health Safety Net Primary and / or Secondary.

2) Eligible services provided to Low Income Patients approved for Health Safety Net Partial, to the extent that such services are in excess of the patient's annual deductible.

3) Eligible services for approved Medical Hardship patients, to the extent that eligible medical expenses exceed the patient's Medical Hardship contribution.

4) Emergency Bad Debt Services – Services provided to an individual uninsured for the services provided and not a Low Income patient, when the services are provided after the onset of a medical condition whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, which a prudent lay person would reasonably believe is an immediate threat to life or has a high risk of serious damage to the individual's health. Conditions include, but are not limited to those which may result in jeopardizing the patient's health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or active labor in women. Examination or treatment for emergency medical conditions or any such other service rendered to the extent required pursuant to EMTALA qualifies as Emergency Care. Such services will only be claimed to the extent that they remain unpaid after 120 days and normal billing and collection activity.

5) Motor Vehicle Accidents and Other Recoveries – The hospital may submit a claim for a Low Income Patient injured in a motor vehicle accident only if we:

    a. have investigated whether the patient, driver, and / or owner of the other motor vehicle liability policy;
    b. has obtained assignment of the patient's right to third-party coverage of claims or possible recovery of claims as the result of tort action, as applicable.
    c. have made every effort to obtain the third party payer information from the patient;
    d. have made diligent efforts to obtain payment from other resources, including personal injury protection (PIP) payments, so that the Health Safety Net Office will be the payer of last resort.
    e. have retained evidence of such efforts, including documentation of phone calls and letters to the patient; and
    f. where applicable, has properly submitted a claim for payment to the motor vehicle liability insurer. For motor vehicle accidents and all other recoveries on claims previously billed to the Health Safety Net, the hospital must report the recovery to the HSN. The recovery will be offset against the claim for Eligible Services.

6) If the hospital bills for eligible services and the Division, or its agent, identifies a third-party resource after the hospital has billed and received payment from the Health Safety Net, the Division, or its agent, will notify the hospital of this available third-party resource.

    a. Upon receipt of the notification, the hospital will remit the HSN payment or provide documentation of the diligent efforts (as defined by regulation and noted in the definitions section) taken to obtain payment from the third party resource.
    b. The Division, or its agent, will review the submitted documentation to determine whether the hospital made diligent efforts.
    c. If the Division, or its agent, determines the hospital did not make diligent

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efforts to receive payment form the third-party, the Health Safety Net may recover the payment by deducting it from future payments.

M. SERIOUS REPORTABLE EVENTS

Lowell General Hospital will not bill the Health Safety Net Office (HSN) for services directly related to a Serious Reportable Event (SRE) as defined by Massachusetts state regulations (105 CMR 130.32(A)).

1) The hospital will not charge, bill, or otherwise seek payment for HSN, a patient, or any other payer as required by state regulation (105 CMR 130.332) for services provided as a result of a SRE occurring on premises covered by the hospital's license, if we determine that the SRE was:

    a. Preventable;
    b. Within the provider's control; and
    c. Unambiguously the result of a system failure as required by 105 CMR 130.332 (B) and (C).

2) The hospital shall not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 130.332 for services directly related to:

    a. The occurrence of the SRE;
    b. The correction or remediation of the event; or
    c. Subsequent complications arising from the event as determined by the Health Safety Net Office on a case-by-case basis.

3) The hospital may submit a claim for services it provides that result from an SRE that did not occur on its premises only if the treating facility and the facility responsible for the SRE do not have common ownership or a common corporate parent.

4) Readmissions to the same hospital or follow-up care provided by the same provider or a provider owned by the same parent organization are not billable if the services are associated with the SRE as described in bullet 2) of this section, above.

IX. DEPOSITS AND INSTALLMENT PAYMENTS

A. PAYMENT PLANS

Patients expressing difficulty in meeting their financial obligations (after all coverage options have been exhausted) will be offered a monthly budgeted payment plan. Specific payment plan guidelines are defined in hospital policy and procedure.

For those patients qualifying for the hospital's Supplemental Financial Assistance Program, there are specific payment arrangement guidelines established in hospital policy and procedure that allow the patient to extend their payment over a longer period of time with a smaller minimum monthly balance.

For those patient qualifying as Low Income Patients pursuant to the Massachusetts Health Safety Net Program: An individual with a balance of $1,000 or less, after initial deposit, must be offered at least a one-year payment plan interest free with a minimum monthly payment of no more than $25. A patient that has a balance of more than $1,000, after initial deposit, must be offered at least a two-year interest free payment plan.

Patients who cease making monthly budgeted payments without establishing alternative arrangement will be subject to the normal Self-Pay Billing and Collection Processes including referral to an external agency.

Payment plans are offered as defined here to all Lowell General Hospital facilities, regardless of on main campus or satellite / off campus location.

B. DEPOSITS

Pursuant to the Massachusetts Health Safety Net regulations pertaining to patients that are either: (1) determined to be a "Low Income Patient" or (2) qualify for Medical Hardship, the hospital provides the following deposits and installment plans. Any other plan will be based on the hospital's own internal financial assistance program, and will not apply to patients who have the ability to pay.

Emergency Services
LGH will not require pre-admission and/or pre-treatment deposits from individuals that require Emergency Level Services or that are determined to be Low Income Patients.

Lowell General Hospital reserves the right to request advance deposits in the following instances:

- Patients to receive elective, cosmetic or non-medically necessary services may be required to pay an amount equal to 100% of expected charges prior to service.

- Patients who do not have verifiable insurance coverage and do not qualify for Low Income Patient Status are required to pay an advance deposit if the service to be performed is of an elective nature. Failure to meet the deposit requirement will result in postponement or deferral of service provided the attending physician's determination is that the procedure is NOT medically necessary.

- Patients traveling from foreign countries to Lowell General Hospital to receive elective, cosmetic or non-medically necessary services will be required to pay the full estimated bill in advance.

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- Low Income Patient Deposits: The hospital may request a deposit from individuals determined to be Low Income Patients. Such deposits must be limited to 20% of the deductible amount, up to $500. All remaining balances are subject to the payment plan conditions established in 114.6 CMR 13.08.

- Deposits for Medical Hardship Patients: The hospital may request a deposit from patients eligible for Medical Hardship. Deposits will be limited to 20% of the Medical Hardship contribution up to $1,000. All remaining balances will be subject to the payment plan conditions established in 114.6 CMR 13.08.

X. DEFINITIONS

1. **Bad Debt.** An account receivable based on services furnished to any patient that is deemed uncollectable following reasonable collection efforts pursuant to the hospital's established credit and collection guidelines, is not the obligation of any federal or state agency and is not considered free care.

2. **Collection Action.** Any activity by which the hospital or its designated agent requests payment for services from a patient or responsible party. A Collection Action shall include requesting pre-admission or pretreatment deposits, billing statements, collection letters, telephone contacts, personal contacts and activities of collection agencies and attorneys.

3. **Diligent Efforts.** Making every effort to identify an obtain payment from all other liable parties, including insurers. Diligent efforts include but are not limited to:

    A. Determining the existence of health insurance by asking the patient if he or she has other insurance and by using insurance databases available to the provider;

    B. Verifying the patient's other health insurance coverage, currently known to the Health Safety Net, through EVS, or any other health insurance resource available to the provider, on each date of service and at the time of billing;

    C. Submitting claims to all insurers with the insurer's designated service code for the service provided;

    D. Complying with the insurer's billing and authorization requirements;

    E. Appealing a denied claim when the service is payable in whole or part by an insurer; and

    F. Immediately returning any payment received from the Division when any available third-party resource has been identified. For the purposes of this definition, a potential property and casualty claim is considered available when the action has been reduced to judgment or settlement, and payment is released.

4. **Emergency Care**. Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, which a prudent lay person would reasonably believe is an immediate threat to life or has a high risk of serious damage to the individual's health. Conditions include, but are not limited to those which may result in jeopardizing the patient's health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or active labor in women. Examination or treatment for emergency medical conditions or any such other service rendered to the extent required pursuant to EMTALA qualifies as Emergency Care.

5. **EVS System.** The MassHealth Eligibility Verification System of the Office of Medicaid.

6. **Family.** Persons who live together, and consisting of:

    A. a child or child under age 19, any of their children, and their parents;
    B. Siblings under age 19 and any of their children who live together even if no adult parent or Caretaker Relative is living in the home; or

C. a child or children under age 19, any of their children, and their Caretaker Relative when no parent is living in the home. A Caretaker Relative may choose whether or not to be part of the Family. A parent may choose whether or not to be included as part of the Family of a child under age 19 only if that child is:
   i. pregnant; or
   ii. a parent.

   A child who is absent from the home to attend school is considered as living in the home. A parent may be a natural, step, or adoptive parent. Two parents are members of the same family group as long as they are both mutually responsible for one or more children that live with them.

7. **The Hospital.** Refers to Lowell General Hospital.

8. **Low Income Patient**. A patient meets the financial criteria for free or partial care under the Health Safety Net based on their income and assets for Massachusetts residents. Non-qualifying residents and non-residents of the state of Massachusetts will be screened against the Lowell General Hospital Supplemental Financial Assistance program.

9. **Medical Hardship Patient**. A patient who is not a Low Income Patient and who qualifies for free care under the Health Safety Net due to significant to Medical expenses for Massachusetts residents. Non-qualifying residents and non-residents of the state of Massachusetts will be screened against the Lowell General Hospital Supplemental Financial Assistance program.
10. **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.

11. **Non-Covered Services**. Non-medical services, such as social, educational, and vocational services; cosmetic surgery; canceled or missed appointments; telephone conversations or consultations; court testimony; research or the provision of experimental, unproven, or otherwise medically unnecessary procedures or treatments, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction and any other related surgeries and treatments, including pre- and post-sex-reassignment surgery hormone therapy; the provision of whole blood except for the administrative and processing costs associate with the provision of blood and its derivatives; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); vocational rehabilitation services; sheltered workshops; recreational services; life-enrichment services; alcohol or drug drop-in centers; drugs used for the treatment of obesity; cough and cold preparations; hormone therapy related to sex-reassignment surgery; drugs related to the treatment of male or female infertility; absorptive lenses of greater than 25 percent absorption; photochromatic lenses, sunglasses, or fashion tints; treatment of congenital dyslexia; extended-wear contact lenses, invisible bi-focals; and the Welsh 4-Drop Lens.

12. **Patient Deductible period.** The patient's free care eligibility year as assigned by the Commonwealth of Massachusetts on-line system. The "determination date" commences the one year deductible period.

13. **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.

14. **Resident**. A person living in Massachusetts with the intention to remain permanently or for an indefinite period. A resident is not required to maintain a fixed address. Enrollment in a Massachusetts institution of higher learning or confinement in a Massachusetts medical institution, other than a nursing facility, is not sufficient to establish residence

15. **State Programs**. Health care programs operated and/or funded by a state that pay for health care for certain low-income people. The programs include Medicaid (for patients eligible for Medicaid in other states), MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Common Health and Emergency Aid to the Elderly, Disabled and Children.

16. **Third Party**. Any individual, entity or program that is or may be responsible to pay all or part of the cost for medical services.

17. **Urgent Care**. Medically necessary services provided in a hospital after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing a 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. Urgent Care services do not include elective or primary care.