Patient Credit and Collections Policy	PennState Health Milton S. Hershey Medical Center
Hershey Medical Center – Patient Financial Services	**Policy Number: RC-002**
Replaces: Patient Responsibility Collection Process, 10/06	**Effective: July 2016**
Authorized: Steve Massini, CFO	
Approved: Dan Angel, Senior Director Revenue Cycle	

PURPOSE:

To define the financial responsibility requirements of Penn State Hershey Medical Center (PSHMC) patients while ensuring transparency during the financial continuum of care. This policy is compliant with the requirements outlined in Section 501(r) of the Internal Revenue Code.

DEFINITIONS:

1) **Agency Placement:** Outside collection agencies are retained to collect accounts in a Bad Debt status. When an account is in Bad Debt status, it has not been deemed uncollectible until nine months of unsuccessful collection activity with a primary or secondary collection agency has occurred.

2) **Guarantor:** The person who is financially responsible for a patient's bill. In the case of an adult, the patient will generally be his/her own guarantor. Children under the age of 18 will generally not be listed as the guarantor. If the child's parents are separated or divorced, the parent with primary custody of the child is the guarantor.

3) **Medically Necessary:** Shall mean health care services that a provider, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

    a) In accordance with generally accepted standards of medical practices

        i) For the purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgement.

    b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.

    c) Not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

    d) Services, items or procedures considered investigational or experimental will be addressed on a case by case basis.

4) **Emergent Care**: Care provided to a patient with an emergent medical condition, further defined as:

   a) A medical condition manifesting itself by acute symptoms of sufficient severity (e.g., severe pain, psychiatric disturbances and/or symptoms of substance abuse, etc.) such that the absence of immediate medical attention could reasonably be expected to result in one of the following:

      i) Placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or

      ii) Serious impairment to bodily functions, or

      iii) Serious dysfunction of any bodily organ or part.

      iv) With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or her unborn child.

5) **Urgent Care:** Care provided to a patient with a medical condition that is not life/limb threatening or not likely to cause permanent harm, but requires prompt care and treatment, as defined by the Centers for Medicare and Medicaid Services (CMS) to occur within 12 hours, to avoid:

   a) Placing the health of the patient in serious jeopardy or to avoid serious impairment or dysfunction; or

   b) Likely onset of an illness or injury requiring emergent services, as defined in this document.

6) **Diagnostic Services –** Services or procedures that are used to determine the cause of an illness or disorder. Diagnostic medical care involves treating or diagnosing a problem a patient is having by monitoring an existing problem, checking new symptoms or following up on abnormal test results. Diagnostic Services provide health care providers with the severity or cause of diseases in patients.

7) **Primary or Specialty Care Services –** Services or procedures provided to patients who arrive to the hospital seeking non-emergent or non-urgent medical care or seek additional care following stabilization or an emergency medical condition. Primary or specialty scheduled services are either primary care services or medical procedures scheduled in advance.

8) **Emergency Medical Condition** – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

9) **Elective Services or Procedures –** Services or procedures that are not medically necessary, as determined by the PSHMC medical staff.

10) **Non-covered or Experimental Services or Procedures –** Services or procedures that are established as:

   i) *Experimental / Investigational Services or Procedures* – Medical services, procedures or drugs that have not been approved for general use but are under investigation in clinical trials regarding safety and efficacy. Experimental and investigational services, procedures, or drugs are intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease.

(1) As the treatment protocols are developed for experimental and investigational services, PSHMC will work with the payer community to explain the medical necessity.

ii) *Non-covered Services or Procedures* – Medical services or procedures that are not covered by the patient's insurance plan.

11) **Patient Responsibility:** Any balance due where the financially responsible party is the patient or the patient's guarantor (not a third party payer).

a) Delaying of Care – PSHMC may delay non-emergent services or procedures for those patients repeatedly refusing to establish reasonable patient responsibility efforts for care provided, care provided under the EMTALA policy are excluded.

12) **Billing Statement or Statement:** A bill for services rendered. This can be a summary of activity or a detailed bill, listing each charge on a patient account.

13) **Date of Service (DOS):**

a) Inpatient DOS – the date the patient is discharged from the hospital.

b) Outpatient / Ambulatory DOS – the date the procedure is performed or the patient receives medical care.

POLICY:

PSHMC will pursue payment on patient accounts consistently, regardless of race, primary language, gender, age, religion, education, employment, student status, disposition, relationship, insurance coverage, community standing, or any other discriminatory differentiating factor.

Every patient/guarantor will be given a reasonable time frame and communications to understand their financial responsibility. PSHMC will seek to notify patients/guarantors of their financial responsibility in advance of their service in non-emergent situations. PSHMC may postpone or cancel non-emergent care (as determined by PSHMC medical staff) for any patient who is unable or unwilling to be financially cleared prior to an elective service. Patients will be provided an opportunity to apply for financial assistance in accordance with the Financial Assistance Policy (PFS-051).

Financially cleared will be defined as cooperating and completing with all processes necessary to ensure an exception-free financial continuum, including but not limited to:

- Proof of Insurance
- Correct Demographic Information
- Payment of all applicable out of pocket expenses (i.e. Co-Pay, deductibles, non-covered charges)
- Working with Financial Counselors to attain third party benefits or financial assistance
- Resolving outstanding patient balances for previous PSHMC health care services

Failure to provide the necessary information to the PSHMC could result in the individual's account being forwarded to an outside collection agency for further collection on balances.

Following the provision of care, every reasonable attempt will be made to process a patient's claim through their provided insurance or third-party payor. Any balance after adjudication from the payor will be billed to the patient (or guarantor) based on the explanation of benefits.

In the absence of a third-party or insurance payor, patients will be billed directly. These patients will be considered to be self-pay patients. Self-pay patients will be provided information regarding the financial assistance policy at PSHMC. It is the expectation of PSHMC that all guarantors/patients will make every reasonable and good faith attempt to pay for the services provided by PSHMC. Additionally, it is the responsibility of the guarantor/patient to provide PSHMC with complete and accurate demographic information. Failure to do so may result in the use of extraordinary collection actions.

The guidelines for the expectations of the patient are outlined below.

Patient Financial Responsibility for Scheduled Health Care Services:

a. If it is determined during scheduling or registration that the patient lacks health insurance or has limited benefits, accounts will be referred to a financial counselor.

b. Financial counselors will provide price estimates to all patients upon request.

c. If a patient indicates he/she cannot pay the patient responsibility estimate, financial counselors can prescreen the patient / guarantor to determine if an individual is eligible for governmental programs or financial assistance.

d. Individuals determined to be eligible for government programs or financial assistance will be given options on how to apply.

e. If an individual does not meet the qualifications for governmental programs or financial assistance, the option of monthly payment plan is available.

f. It is the individual's obligation to provide PSHMC with the required financial information requested on the application.

g. All patients requesting financial assistance from PSHMC will be required to provide all necessary information to establish their inability to pay. Services that are not medically necessary may be postponed or cancelled for patients who are uncooperative or are unable to assist PSHMC by providing necessary information to establish their ability to pay or need for financial assistance.

h. Medical necessity will be determined by the PSHMC provider and medical staff. Please refer to the definition of Medically Necessary under the Definitions section of this document.

i. Financial counselors will contact the providers and ask them to provide additional information relative to the patient's medical condition and need for immediate attention. Only services deemed not medically necessary will be postponed or cancelled as determined by the PSHMC medical staff, see the **Financial Risk Procedure.**

j. PSHMC will continue to provide medically necessary services while financial counselors proactively work with the patient to satisfy financial obligations.

k. Failure to provide the necessary information or establish a month payment plan could result in the individual's account being forwarded to an outside collection agency for further collection on balances.

Following the provision of services, guarantor balances and self-pay balances will be billed to the guarantor. The following are the guidelines for this billing statement process.

Billing Statements

a. A statement of hospital and/or physician services is sent to the patient/guarantor in four incremental thirty day billing cycles.

b. Revenue Cycle representatives or contracted vendors may attempt to contact the patient/guarantor (via telephone, mail, collection letter, or email) during the statement billing cycle in order to pursue collections or pursue financial assistance opportunity. Collection efforts are documented on the patient's account in the billing system. Every reasonable attempt will be made to contact the patient regarding their outstanding balance.

c. The final billing statement message indicates that the account may be referred to an outside collection agency if it is not paid within 30 days from the date of the letter.

d. Patients or guarantors who are actively engaged with PSHMC Patient Financial Services, as determined by PSHMC, regarding financial assistance will not have their accounts sent to a Collection Agency.

e. Patients/Guarantors will continue to receive billing statements while actively engaged with PSHMC Patient Financial Services and the financial assistance application process.

It is the patient/guarantor's obligation to act in good faith and make reasonable efforts to pay for services provided at PSHMC. Patients who do not wish to apply for government assistance, do not qualify for financial assistance, or who are over the income requirements and need assistance paying for services may request a payment plan. The following are guidelines for establishing a payment plan.

Payment Plans

a. PSHMC offers a payment plan arrangement if a patient/guarantor is unable to pay their bill in full and is not eligible for financial assistance.

b. The payment plan is based on the outstanding amount due and it requested to be resolved within a reasonable amount of time as determined by PSHMC (6-24 months), see **Payment Plan Guidelines**.

c. Individuals who have not entered into a formal payment plan with PSHMC could be subject to an outside collection agency for further collection.

d. Individuals are expected to make payments on time each month.

e. An account becomes delinquent when the patient/guarantor does not pay the agreed monthly payment within 30 days of the statement date. Delinquent accounts could be subject to an outside collection agency for further collection.

f. If a patient/guarantor anticipates missing a payment or household income has changed, the individual can apply for financial assistance; see the **Financial Assistance Policy (PFS-051)**.

PSHMC may pursue further collection on balances in the absence of reasonable efforts by the patient or guarantor to pay for an outstanding bill. This includes but is not limited to, not providing the necessary information to complete the financial assistance process. The following are guidelines for the extraordinary collection actions process.

Extraordinary Collection Actions

a. PSHMC does not assign accounts for external collection nor engage in extraordinary collection actions before making reasonable efforts to determine whether the patient is eligible for Financial Assistance.

   i) PSHMC will provide notices during a notification period ending 120 days after the date of the first billing statement.

b. The outside collection agencies may report accounts to external credit reporting agencies. Patient Financial Services and the outside collection agencies will comply with the Fair Debt Collection Practices Act and Federal Trade Commission Telephone Consumer Protection Act, and 501(r) regulations throughout all collection activities.

c. Bad Guarantor Address (BGA) – PSHMC will make reasonable efforts to respond to all patient statements returned by the USPS that are not deliverable. Accounts whose most recent demographic information contains a BGA may be referred to an outside agency as bad debt for additional follow up for 120 days prior to placement, however these accounts will not be subject to an extraordinary collection action event until the requirements of notification are satisfied. It is the intent of this policy to be in compliance with 501(r) regulations.

d. District Magistrate or Attorney Placement – In certain cases based on the outstanding balance and ability to pay, PSHMC may pursue legal action to collect patient balances.

e. Termination of Physician/Patient Relationship – PSHMC can terminate a patient/physician relationship if the patient is delinquent in paying for care. Medical Director, Manager and Physician must all agree to terminate patient and agree on level of termination. See **Patient Dismissal Policy (135-MGM).** Delinquent in paying for care includes, but is not limited to:

   i) Non-payment or substantial underpayment of clinic bills, despite the capacity to provide payment (efforts should be made to assist patients in establishing reasonable payment plans and secure financial assistance when possible, see PFS-051 Financial Assistance Policy)

   ii) Refusal to cooperate with Revenue Cycle staff to enroll in applicable third party payer programs in securing assistance.

It is the intent of PSHMC that this policy is within the guidelines and regulations set forth in the Federal Register under Section 501(r) and under the CMS Regulatory Requirements regarding Medicare bad debt.

PERSON RESPONSIBLE FOR REVIEW OF POLICY

Senior Director Revenue Cycle

Reviewed: 01/05/2008, 1/1/2009, 7/1/2009, 2/2010 Revised: 01/05/2008, Revised 6/10/11, Revised: 07/01/2016

Patient Financial Services	Policy Number: RC-002
Patient Responsibility Collection Policy and Bad Debt	Effective: July 2016