Patient Responsibility Collection Policy and Bad Debt	PENNSTATE HERSHEY Milton S. Hershey Medical Center
Hershey Medical Center – Patient Financial Services	**Policy Number: PFS-021**
Replaces: Patient Responsibility Collection Process, 10/06	**Effective: January 2008**
Authorized: Kevin Haley	
Approved: Lisa Brown	

PURPOSE:

To define the policy for billing and collection of self-pay account receivables, ensuring reasonable collection efforts are administered. This policy assumes that the outstanding balance pursued is owed by the patient/guarantor.

DEFINITIONS:

Agency Placement: Outside Collection Agencies are used to collect accounts in Bad Debt Status. When an account is in Bad Debt Status, it has not been deemed totally worthless and uncollectible. After the lessor of either the Outside Collection Agency exhausting all avenues for collection or 15 months from placement have elapsed with no reasonable activity, the account will be returned to PSHMC and deemed totally uncollectible.

Group Policy: The insurance policy purchased on behalf of the Guarantor by a larger (typically Employer) group.

Guarantor: The person who is financially responsible for the patient's bill. In the case of an adult, the patient is his/her own guarantor. Children under the age of 18 cannot be listed as their own guarantor; you need to ask who the adult is that is financially responsible for the child. If the person presenting the child for the appointment is someone other than a parent (i.e. babysitter, grandparent, neighbor, etc), they need to provide the parent's information that shall be entered as the guarantor. If the parents are separated or divorced, ask for the name of the parent who has custody of the child. If the custody arrangement is 50/50 for each parent, then either parent can be the guarantor.

Medically Necessary: Medical Necessity is determined by a combination of the clinician's documentation and evaluation and third party payer restrictions.

Patient Responsibility: Any balance due where the financially responsible party is the patient or the patient's guarantor (not a third party payer). Also known as "Self-Pay".

Patient Statement or Statement: A bill for services rendered. This can be a summary of activity or a detailed bill, listing each charge (and credit, if applicable) on a patient account.

POLICY:

Payment on accounts will be pursued consistently, regardless of: race, primary language, gender, age, religion, education, employment or student status, disposition, relationship, insurance coverage, community standing, or any other discriminatory differentiating factor.

Every Guarantor will be given reasonable time and communication to be aware and understand their financial responsibility. The guarantor will be held financially responsible for services actually provided and adequately documented. In most cases, the patient will be notified in advance of the financial responsibility if the elective service is delivered. Understanding each guarantor's insurance coverage is the responsibility of the guarantor. Any self-pay liability secondary to insurance coverage is defined by the guarantor's Group Policy. PSHMC will rely on the insurance carrier for identifying self-pay balances.

PROCEDURE:

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

- PFS representatives may attempt to contact the patient/guarantor (via telephone, mail, collection letter, or email) during the statement billing cycle in order to pursue collections. Collection efforts are documented on the patient's account.

- The final statement message indicates that the account will be referred to an outside collection entity if not paid or resolved.

- After the final statement and no contact made by the guarantor/patient the account will qualify for automatic placement with the outside collection agency (109-147 days on the hospital accounting system and 124 days on the physician accounting system).

Reasonable Collection Efforts

To be considered a reasonable collection effort as stipulated in the CMS Provider Reimbursement Manual (PRM) 15-1, Section 310 requires that a provider's effort to collect must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. The PRM indicates that the collection effort should include other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

- Bad Guarantor Address: (BGA) PFS will define a process for any statement returned due to an incorrect or "bad" address (see Appendix A). Reasonable measures will be taken to locate the correct address. If reasonable attempts fail, the standard practice (defined below) for an account in consideration for Outside Collection Agency placement will be followed.

- Budget Payments: When an under-insured or uninsured patient contacts Patient Financial Services, a variety of payment arrangements are available. The PFS Representative may set up a 'budget', 'contract', or installment payment. A patient, who has a balance of $1,000 or less, will be requested to make monthly installment payments so that the bill is paid within one year. A minimum of $25 per month must be arranged. A patient with a balance greater than $1,000 will be requested to make monthly installment payments that ideally will be paid within a two year period. As long as the account is in a "budget" financial class it remains on active A/R

- If the patient defaults on a payment, the account will transfer to a bad-debt status (placed with an outside collection agency). At that point the financial class would reflect bad-debt. Once the account is with the agency and the patient is set up on a budget it remains in bad debt until paid in full or the account is returned from the Outside Collection Agency as "NPC", no longer pursuing collections.

- Early Transfer to Collection Agency: During the course of reasonable collection efforts, the account can be manually transferred to an outside collection entity (collection agency, district magistrate, collection attorney) at any time during the statement billing process based on the patient's refusal to pay, bad debt history, credit report review, non-responsiveness to our collection efforts, or management discretion.

- District Magistrate of Attorney Placement: The decision to place an account with the district magistrate or the collection attorney is based on outstanding balance amount and ability to pay. There are instances that an account is placed with the district magistrate or collection attorney when the patient/guarantor is required to complete a form for the insurance carrier and has not done so or when there is third-party litigation pending.

- In the case that the account was initially placed with the District Magistrate or Collection Attorney and returned to HMC as uncollectible, the account may be referred to the outside collection agency to pursue further collection efforts.

Use of Collection Agencies

Section 310(A) of PRM 15-1 permits the provider's collection effort to include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts.

- The outside collection entities may report the account to the credit reporting bureau. PFS and the outside collection entities will follow the Fair Debt Collection Act during collection activities.

- After 15 months with the outside collection agency, if the account remains unpaid, it will be returned to HMC as "No Longer Pursuing Collection" (NPC) via an electronic file.

- The hospital billing system will reflect a financial class change from "Bad Debt" to "NPC" and no further collection efforts will be made. When notification is received from the collection agency the likelihood of recovery is none. However, if recovery is received, it will offset the original bad debt.

- While the account is not actively being pursued for collections, balances greater than $50.00 will remain on the patient's credit report.

- Authorization: Any account following the above standards for Bad Debt, will be considered and authorized for write-off to the final Bad Debt Status. Any deviance from either the placement to an Outside Collection Agency or to Final Bad Debt (totally worthless) status requires additional approval. For the Schedule for Approval, see **PFS Policy PFS-008 Account Adjustment Authorization Policy**

Bad Debt Recoveries

In some cases an amount previously written off as a Medicare bad debt may be recovered in a subsequent accounting period. When this occurs 42 CFR 413.89(f) provides that the income must be used to reduce the cost of beneficiary services for the period in which the collection is made. Additionally, PRM 15-1 316 provides that such reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period.

Allowable Medicare Bad Debt Defined

The Code of Federal Regulations (CFR) at 42 CFR 413.89(e) defines the criteria for an allowable Medicare bad debt. It requires that the Medicare bad debt meet four basic criteria: (1) the debt must be related to covered services and derived from deductible and coinsurance amounts; (2) the provider must be able to establish that reasonable collection efforts were made; (3) the debt was actually uncollectible when claimed as worthless and; (4) sound business judgment establish that there is no likelihood of recovery in the future.

- At any time during the course of reasonable collection efforts, it is determined that the patient cannot afford to pay for the outstanding debt, charity care is considered as outlined in our Charity Care Policy.

Charity Care

According to 42 CFR 413.89(b) (2) charity allowances are reductions in charges made by the provider because of the indigence or medical indigence of the patient. The PRM 15-1 Section 328 clarifies that charity care, courtesy, and third-party payer allowances are not reimbursable Medicare costs and cannot be claimed as Medicare Bad Debts.

PERSON RESPONSIBLE FOR REVIEW OF POLICY Assistant Director, Patient Financial Services

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