

MONTEFIORE MEDICAL CENTER
The University Hospital for the
Albert Einstein College of Medicine

POLICY AND PROCEDURE

SUBJECT: Collection Policy/Bad Debt

NUMBER: 30

OWNER: Health Service Receivables

**EFFECTIVE
DATE: 4/00**

**REVISED
DATE: 09/25/12**

SUPERSEDES: 07/15/11

REFERENCE: Unpaid Claim Follow Up, Patient/Guarantor Billing Policies, Termination of Follow up.

OBJECTIVE: The Health Service Receivables Department is committed to assuring that after exhausting all reasonable follow-up efforts; unpaid self-pay claims are referred to external agencies for further collection effort and the account classified as bad debt.

SCOPE: HSR associates responsible for collection of self-pay balances.

DEFINITIONS: Self-pay refers to accounts for patients with no insurance, patients with a balance after insurance payment, or insurance denials where patient is made responsible for balance.

OPERATING PROCEDURE:

Payment Arrangement Plan Criteria- Prior to an account being referred to bad debt it may be placed on a payment arrangement plan if the monthly payment amount requested and agreed to by the patient/patient representative falls within H.S.R. payment arrangement guidelines which are as follows:

<u>Balance Due</u>	<u>Number of Months</u>
Less than \$100	1-3
\$100.01-\$300	3-4
\$300.01-\$500	4-6
\$500.01-\$800	6-8
\$800.01-\$1500	8-12
\$1500.01-\$2500	12-16
\$2500.01-\$4000	16-20
Greater than \$4000	20-24

Payment arrangement requests made by the patient/patient representative which fall outside of the guidelines require review and approval by the self pay manager.

Bad Debt Qualification Criteria – An account may be referred to collection if it meets one or more of the following criteria:

- Self-pay balance not paid 120 days after bill date when all reasonable follow-up efforts have been exhausted.
- Patient/Guarantor advises HSR associate that they have no intention of paying the bill
- Patient communication via mail and/or phone is unsuccessful due to bad information

Please note that bad debt adjustments require adequate system notes to demonstrate justification, reconciliation and an audit trail before referring self-pay accounts to collection agencies.

1. If a self-pay account that has been billed remains unpaid for over 120 days and all reasonable collection efforts have been exhausted, the account will be referred to bad debt. Reasonable collection efforts include:
 - A. Sending an initial self-pay bill for the balance and subsequent statements at 21 and 42 days from bill date
 - B. Reviewing previous accounts in the Eagle and/or IDX billing systems to

determine if a valid third party payer exists for date-of-service.

- C. Name search for Medicaid via Electronic Medicaid Eligibility Verification System (EMEVS) on Eagle to determine if patient has Medicaid coverage.

Self-pay patients must always receive a bill prior to referring to collection.

2. Self-pay accounts are referred to Tele-Computer Systems (TCS) 45 days after bill date where follow-up takes place for 45 days. At least twice a week phone calls (by telephone representatives as well as automated outbound message campaign) are made by H.S.R. in an attempt to resolve the outstanding balance with the patient/patient representative. Twice a month TCS runs a query of accounts qualifying for collection. A Final Notice letter is mailed to patients whose accounts appear on the query and if no response is received within 15 days from the final notice letter being mailed the account is transferred to the bad debt financial class. The Emerging Health IT department sends an electronic file to the agency.

Accounts may also be referred to collection by changing the step codes. If an associate determines that an account should be referred immediately to collection, the step code will be changed. The associate will code the account accordingly and Eagle will automatically transfer the account to the collection financial class. Associate will discuss with a Manager/Supervisor, any accounts with a balance over \$25,000 before being referring to collection and the Manager will approve such accounts and note systems accordingly.

3. Inpatient Medicare – There are 3 types of Medicare patient balances that can be classified as Medicare bad debt:
 - A. Co-insurance
 - B. Deductible
 - C. Life Time Reserve Days (LTR)

As with all collection referrals, prior to classifying a Medicare account as bad debt, associates must have attempted and clearly documented 3 prior collection efforts.

4. Any inquiries received within 10 days of the agency referral should be handled internally (including recalling accounts if patient provides information or payment is received) as the agency may not have the account detail loaded into their system yet.

5. Any patient inquiries/payments received after 10 days of an agency referral will be referred to the agency.
6. Any payments recovered from the agency are sent to MMC with a remittance advice and will be posted to the account as “Collection Agency Recovery”.
7. A request to recall an account from the agency may be received for:
 - A. Accounts paid prior to bad debt referral but payment was not posted
 - B. Misapplied payments
 - C. Patient never had services (must be confirmed)
 - D. Patient disputes charges (must be confirmed)
 - E. Administrative Reasons/Patient Relations Issues
 - F. Unapplied Allowances
 - G. Special Programs (i.e. NYC Child Health Programs)
 - H. Risk Management
 - I. Financial Aid
 - J. Insurance was found and verified by H.S.R.

Requests to recall an account from the agency will be referred to the appropriate Manager/Supervisor and will be accompanied by a log sheet indicating the reason for the request. These accounts must be reversed from bad debt and transferred back to the last billed financial class (a note will be entered on the transfer screen indicating reason for transfer) and the Collection Manager will send the agency the log sheet to notify them of the reversal. Requestor will also be notified of recall.

The Collection Agencies are advised to indicate on their collection letters that the patients may be eligible for financial assistance pursuant to our Financial Assistance Policy.

Financial aid will be available to:

- Uninsured patients residing in Montefiore service area receiving medically necessary services who do not have the ability to pay based on formal financial criteria
- Patients receiving services who have insurance coverage but who incur an out-of-pocket expense may be eligible for financial assistance, including an extended payment arrangement upon request. Any financial aid allowance will be made on a case-by-case basis.

8. If an account is returned by a collection agency with a status of “all collection efforts exhausted”, the Collection Manager will determine if the account should be closed and allowed to zero or manually referred/transferred to a secondary agency. All activity will be documented in comments. Also refer to the Manual Contractual Adjustments Policy for account adjustment protocol.

Primary Collection Agency Criteria- Once an account is referred to the Primary Collections agency they will go through their internal process looking for active Medicaid insurance, address and telephone verification and a return mail process. In addition, credit reports and asset searches will be done. Upon completion of this process, the following collection efforts will be made:

- At least 1-4 letters sent
- At least 1-4 telephone calls made
- Deceased and Bankruptcy patient accounts will be returned for write off
- Accounts with mail return and no phone number are closed and returned to MMC for referral to secondary collection agencies
- Accounts in active collections 180 days from referral date are closed and returned to MMC for referral to secondary collection agencies
- Accounts which qualify for legal action (judgment filing) are sent to MMC self pay manager for approval prior to proceeding with such action. Accounts will remain open with the agency until court proceedings are completed

Secondary Collection Agency Criteria- Once an account is referred to the Secondary Collection agencies they will go through their internal processes looking for active Medicaid insurance, address and telephone verification and a return mail process. In addition, credit reports and asset searches will be done. Upon completion of this process, the following collection efforts will be made:

- At least 1-4 letters sent
- At least 1-4 telephone calls made
- Deceased and Bankruptcy patient accounts will be returned for write off
- Accounts with mail return and no phone number are closed and returned to MMC for write off
- Accounts in active collections 90-180 days from referral date are closed and returned to MMC for write off
- Accounts which qualify for legal action (judgment filing) are sent to MMC self pay manager for approval prior to proceeding with such action. Accounts will remain open with the agency until court proceedings are completed