

Title: Patient Billing and Collections Policy	Page 1 of 7
Policy #: MA1024	
Type: Business Office	
Standard: N/A	

PURPOSE:

The intent of this policy is to establish the guidelines and procedures for direct patient billing and collection procedures for non-payment of patient balances.

POLICY:

Patients with account balances that are their responsibility for payment will be billed to the patient or their guarantor per the provisions of Methodist's financial assistance policy and the procedures listed in this collections policy. Patient balances may be the result of assigned liabilities after payment from an insurance plan or government program such as Medicare, as well as liabilities from being uninsured. All billing and collection activities shall be in compliance with the Hospital Fair Pricing Policies law, Section 501(r) of the Internal Revenue Code and Fair Debt Collection Practices Act.

DEFINITIONS:**A. Financial Assistance**

Financial Assistance is financial aid to a patient or responsible party for the billing amounts the patient is responsible, regardless if the patient has insurance or otherwise. Financial assistance is primarily based upon the patient's economic need. Financial Assistance does not include discounts normally given to insurance policy holders, contract prices that are negotiated with insurance companies or other adjustments once the final bill has been created. When the patient is able to pay part of their bill, consideration will be given to writing off a portion of that account as partial financial assistance. Financial Assistance may also include assistance to patients who have incurred high medical costs as defined as yearly healthcare costs greater than 10% of household income.

Financial Assistance is not to be considered a substitute for personal responsibility and patients are expected to cooperate with Methodist Hospital's procedure for applying for Financial Assistance, and to contribute to the cost of their care based on their individual's ability to pay.

This policy and the MHSC Financial Assistance obtained by calling (626) 574-3594 and asking for a financial counselor or can be found on the MHSC Web site at:

<https://www.methodisthospital.org/For-Patients-Visitors/Financial-Assistance-for-Patients.aspx>

Number: MA1024	Title: Patient Billing and Collections Policy	Page 2 of 7
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B. Financial Assistance Patients

Financial Assistance Patients (FAP) are defined as follows:

1. Uninsured patients (those without third party insurance, Medicare, Medi-Cal, or with injuries or conditions qualifying for coverage worker's compensation or automobile insurance for injuries) who do not have the ability to pay based on criteria described in the Eligibility section below.
2. Insured patients whose insurance coverage and ability to pay are inadequate to cover their out of pocket expenses.
3. Insured patient unable to pay for portion of the bill due to uncollected co-payments, deductibles and non-covered services.
4. An insured or uninsured patient with high medical costs, whose household income does not exceed 350% of the federal poverty level, but whose out-of-pocket medical costs or expenses exceed 10% of their income for the prior year.
5. Any patient who demonstrates an inability to pay, versus bad debt, which is the unwillingness of the patient to pay.
6. The hospital will not base its determination that the individual is not eligible for financial assistance based on information that the hospital has reason to believe is unreliable, incorrect or on information obtained under duress or coercive practices.

C. Amount Generally Billed

The Amounts Generally Billed (AGB) is defined as the maximum amount a patient who qualifies under the financial assistance policy for a charity or other discount which is equal to the average amounts historically allowed as a percentage of billed charges for all services provided under the Medicare program for a 12-month look back period calculated in accordance with IRC 501 (r). Inpatient services will be priced at a certain percentage of billed charges on a sliding scale reflecting the different levels of utilization of services. Outpatient services will be priced at the hospital's average outpatient Medicare allowed amounts as a percentage of billed charges during the same 12-month look back period as mentioned above for inpatient. Please see policy MA1023 appendix A for the AGB calculation.

D. Extraordinary Collections Actions

As defined in Section 501(r) (6) of the Internal Revenue Code, Extraordinary Collections Actions (ECAs) are collection activities that may be taken against a patient or guarantor for non-payment that include but not limited to the following:

1. Reporting adverse information to credit agencies.
2. Placing a lien on an individual's property except those allowed under state law due to judgments or settlements as part of a personal injury case.
3. Foreclosing on real property as permissible under state and federal regulations.
4. Attaching or seizing an individual's bank account or any other personal property.
5. Commencing a civil action against an individual or writ of body attachment.
6. Garnishing an individual's wages, in accordance with the state and federal regulations
7. Certain sales of the patient's debt to another party.

Extraordinary collection actions does not include a lien asserted on the proceeds of a judgment, settlement or compromise owed to an individual as a result of a personal injury for which medical services were provided. Moreover, the AGB and FAP protocol does not apply to trusts, estates, partnerships, associations, corporations, LLCs, government agencies, nonprofits or businesses that assume the individuals debt. However, with regards to actions within this policy the facility will consider any individual who has accepted or is required to accept responsibility for an individual having medical treatment rendered as equivalent to the first individual receiving a hospital bill for the care.

PROCEDURES

A. Initial Patient Billing

1. Patients without insurance or coverage by any government sponsored program will receive an initial patient billing statement usually within 10 days of the discharge date.
2. All charges that are billed directly to a patient who is uninsured or not covered by a government sponsored program will be billed at or discounted down from the hospital list price to the amount that is generally billed to Medicare, consistent with the patient type (DRG for inpatient and OPSS for the outpatient). With the financial assistance application approval, this will be revised to the AGB.
3. The initial patient billing statement will include a plain language version of the hospital's financial assistance policy including information on how to apply for financial assistance.
4. For patients with primary insurance coverage, any balances remaining after the primary insurance payment; i.e. deductibles, co-payments, co-insurance, non-covered charges, will be billed to the patient usually within 10 days of the primary insurance payment.
5. All patients may pay any amounts due over time and the hospital will negotiate a payment arrangement in good faith.

B. Statement Billing Cycles

1. Balance due statements are generated every 30 days after the date of the initial statement.
2. Two statements will be generated by the hospital during the first 60 days after the initial self-pay billing.
3. After 90 days the unpaid amount will be assigned to a pre-collection vendor for further follow-up activity. While the account is with the pre-collection vendor 3 outgoing calls or statements will be made to the guarantor.
4. The duration of the pre-collection activity will take 90 days and the account remains on the active accounts receivables at the hospital and not written off to bad debt.
5. Upon completion of the pre-collection cycle, the account will be written off to bad debt and referred to a collection agency, predetermined by an alpha split of the guarantor last name.
6. No account will be assigned to collections prior to 150 days from the first patient billing, or while a financial assistance application is being processed. To the extend a FAP application is received, prior to 240 days post discharge, MHSC will be recall the billing, stop any ECAs that may have occurred and process this account in accordance with the FAP Policy.

Number: MA1024	Title: Patient Billing and Collections Policy	Page 4 of 7
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7. Patients on a formal payment plan will receive a monthly statement of the current amount due until the payment plan is satisfied.

C. Insurance Underpayments

1. Upon the identification of an insurance underpayment (underpaid in accordance with the contract with the insurance payer), the Patient Accounting Representative will confirm the patient liability (co-pay, deductible and/or co-insurance) on the account. If the patient's financial responsibility is outstanding and clearly identified by their insurance company, a courtesy patient balance letter will be generated and sent to the guarantor's address on file.
2. The patient balance letter (also referred to as the co-pay letter) will include information such as the patient's account number, date of service, and patient's full name along with the balance owed by the guarantor.
3. The patient balance letter will include a plain language summary of the hospital's financial assistance policy including information on how to apply for financial assistance.
4. A note is to be entered in the patient's account in the computer accounting system indicating the date of mailing and the amount owed by the guarantor.
5. Active collection efforts from the patient (such as data mailers/statements and transfer to our pre-collection vendor) will not occur until collection efforts from insurance has ceased.

D. Payment Arrangements

All patients may pay any amounts due over time and the hospital will negotiate a payment arrangement in good faith. All payment arrangements will be made with the following limits:

1. Twelve (12) month re-payment plan will be offered with minimum monthly payments of \$25/month.
2. Twenty-four (24) month re-payment plan will be offered for special circumstances or hardships with Supervisor approval.
3. Re-payment plans beyond 24 months will require approval from the Director of Patient Financial services.
4. The patient/guarantor will be given the option as to the day payment will be made each month.
5. Ten (10) days from the agreed day will be allowed as grace period for the payment to be received and posted to the account.
6. Any previously agreed payment not received within the specified grace period will be considered in default and may be referred to our pre-collection vendor.
7. All payment arrangements will be clearly documented in the "Notes" section of the patients account.
8. When a payment arrangement is made, the Patient Account Rep will add a note and code the account to insurance 760-Cash Payment/Arrangements and set up the payment plan in Affinity under Account Control - Payment Plan.
9. Patients set up on a formal payment arrangement and making monthly scheduled payments will not be assigned to collections unless the payment plan is delinquent.

E. Collection Agency Assignment of Delinquent Accounts

1. Accounts will be sent to a collection agency for non-payment of the account and lack of applying for financial assistance or contacting the hospital to make payment arrangements.
2. If a patient is covered under the hospital's financial assistance program with an extended payment plan and the payments are not met, the hospital must take the following actions before an account can be assigned to a collection agency:
 - a. Attempt to contact the patient by phone.
 - b. Give notice in writing that the plan may become inoperative.
 - c. Inform the patient of the opportunity to renegotiate the payment plan and attempt to do so if requested by the patient.
 - d. The notice and phone call may be made to the last known phone number and address of the patient.
3. After the final statement for a delinquent account is issued the account is reviewed a final time before assignment to a collection agency to ensure that a financial assistance application is not pending. The Hospital's Executive Director of Finance will review the bad debt placement report(s) and approve for bad debt placement as appropriate with the following considerations:
 - a. Defaulted installments (2 installments).
 - b. Patient/Guarantor refusal to pay.
 - c. Non-sufficient funds (NSF) check.
 - d. No financial assistance application on file.
 - e. Inaccurate demographic data where the hospital cannot determine a valid address.
4. Methodist Hospital contracts with multiple external collection agencies but retains full ownership of the accounts receivables and has the final say in any account resolution.
5. Patients who provide inaccurate demographic data and where the hospital cannot determine a valid address may be sent to collections earlier than 150 days.
6. The contracted collection agencies must follow the hospital's financial assistance policy in all terms related to the application for assistance procedures and time frames, negotiating payment plans and the rules for engaging in ECA's.
7. ECA's will not be initiated against a patient during the first 150 days after the first billing statement was mailed; this includes negative reporting to credit bureaus.
8. The patient will be informed in writing no less than 30 days before any ECA's are initiated. The 30 day notice will include the plain language version of the financial assistance policy.
9. The pre-collection vendor is responsible for making this notification before any and all ECA's are initiated. The hospital is ultimately responsible for the collection agency actions.
10. If a financial assistance application is made when an account is already assigned to a collection agency, the agency will put the account on hold during the duration of the application process.
11. If the hospital is made aware of any verified Medi-Cal or other insurance coverage, the account will be recalled from the agency and the insurance billed for the service.
12. Any legal actions against a patient including liens, lawsuits, wage garnishments, etc., must be approved by the Executive Director of Finance, and the proper 30 day notice in advance of such activities must be completed by the collection agencies.
13. Upon request, or when contacting the patient regarding their bill regarding legal action, MHSC will provide a referral to a local consumer assistance center for legal services, in accordance with state regulations.

Number: MA1024	Title: Patient Billing and Collections Policy	Page 6 of 7
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14. The fact that a patient has accounts in bad debt will not be used as a reason to deny future emergency medical services at the hospital.

F. Incomplete FAP Application

In the case of an individual who submits an incomplete FAP application during the application period MHSC will notify the individual regarding the areas that are incomplete and inform them of the items and or process necessary to complete the FAP Application. MHSC will allow the patient 30 days, from the documented notification, to amend the incomplete application.

1. If the incomplete application is within the initial 150 of the initial billing the patient will have up to the 240 days to complete the incomplete application, but will be encouraged submit the amendments within the next 30 days.
2. If the incomplete application is within the period of 210 and 240 days of the initial billing, MHSC will notify the patient, in writing, of the incomplete FAP application and the letter will serve as notification of MHSC intention to initiate a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date. Thus, the patient will have 30 days from the notification day to comply.

G. Credit Balance on Patient's Account

All refunds are processed in accordance with regulatory guidelines to include Section 1371.1 of the California Health and Safety Code, which says, "the providers shall reimburse the health care service plan within 30 working days of receipt ... of the notice of overpayment, unless the overpayment or portion thereof is contested in writing, within 30 working days." Resolution of requested refunds of all amounts will be the first priority of the Hospital and will be issued to the patient, guarantor or insurance company only after the hospital, or Methodist Hospital contracted 3rd party, has performed sufficient research to determine that the requesting party is the appropriate party to receive funds. Other refunds of all amounts will be processed after all requested refunds have been resolved and in accordance with California Escheat laws.

Upon the review of an account showing a credit balance on the hospital financial system and once it has been determined the account is overpaid or incorrectly paid and refund is due patient, the patient account representative will perform the following process:

1. Enter detailed comments into the financial system to explain how refund calculation was completed.
2. Obtain appropriate documentation such as copy of patient check or copy of Explanation of Benefits (EOB) for insurance payments and determine appropriate payee.
3. Review other accounts which the patient might have and which may be affected by the refund request.
4. Complete a "Refund Authorization Request" Form and submit for appropriate approval.
5. A refund letter is completed and attached to the refund request.
6. Approved refunds will be given to Cashier and posted into the hospital financial system on a weekly basis.
7. Once posted, refund requests are referred by the Cashier to Accounts Payable for issuance.

Number: MA1024	Title: Patient Billing and Collections Policy	Page 7 of 7
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8. Accounts payable produces the refund checks and delivers to the Cashier who mails the refund check with any attachments.

H. Payment Transfers between Patient Accounts

1. Payment transfers are used when an account has a credit balance caused by an overpayment which should be applied to another unsatisfied account balance.
2. Transferring patient payments between accounts is only appropriate when there is documented patient liability on the open balance account including bad debt. It is not appropriate to apply a self-pay payment to an insurance only balance.
3. The Patient Account Representative will thoroughly research the credit balance account and any other open account balance the patient has prior to requesting the money to be transferred. If the open account balance is due to verified patient liability, a money debit/credit transaction would be appropriate.
4. The process to transfer patient payments between accounts involves the following steps:
 - a. The Patient Account Representative will have the original patient payment check pulled and copied (look under original payment date).
 - b. Using the payment transfer request form, document all payment codes and amounts of both the debit and credit transactions (use the same payment codes associated with the original payment).
 - c. Enter clear and concise notes in the computer accounting system documenting, in both accounts, the reason for the debit/credit transactions.
 - d. Send notification to collection agency if credit was transferred to a bad debt account to notify of new balance.
 - e. Submit all of the above documents to the Supervisor/Manager for signature.
 - f. The Supervisor/Manager will submit to Cashier for processing.

REFERENCE:

System Generated Footer

Attachments:

Approvals:

CFO: 2/14

Board of Directors: 4/16

Business Office: 11/04, 8/08, 9/11, 2/14

Governing Policy and Procedure Committee: 2/14, 4/16

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Reviewed Dates: 11/04, 8/08, 9/11, 2/14, 4/16

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