THE CHAMBERSBURG HOSPITAL

Subject: Billing and Collection Policy		**Original Date:** 2/2003
Department: Finance		**Revision Date(s):** 9/30/2011. 3/2012, 2/2013, 6/2014, 7/2015, 7/2017, 12/2017
Area: Patient Accounting	**Discipline:**	
Classification:		**Review Cycle:** Annually

PURPOSE: To specify guidelines followed in collecting self pay account balances.

POLICY: It is the policy of The Chambersburg Hospital to collect patient balances consistently among patients, using inhouse and outsourced resources.

CONTENT:

1. Patient balances are collected using a series of inhouse efforts. They include:

   a) If there is no insurance, the original detailed bill is sent to the guarantor. It is accompanied by a letter offering a prompt pay discount and other payment assistance options. A Summit Care application and Plain Language Summary of our policy is included.

   b) Thirty days later, a statement with summarized charges and a Summit Care application is sent to the guarantor informing them that their account is past due and asking them to pay the balance.

   c) Fifteen days later, accounts $5000 and over go to the worklist of a patient account representative. Staff contacts as many guarantors as time permits each week to try to collect the balance.

   d) Twenty-five days later accounts <u>$250 or more</u> are referred to a third party healthcare financing company who attempts to set up no-interest payment plans. Accounts with them don't receive statements from the hospital. The third party healthcare financing company is not a collection agency. See 6. below.

   e) Five days later (or a total of 45 days from last statement), accounts <u>less than $250</u> are sent a third notice with summarized charges and a Summit Care application. It asks the guarantor to call to make payment arrangements and warns them that the account will be referred to a collection agency if payment is not received.

   f) Thirty days later, a fourth correspondence in the form of a final

notice letter and a Summit Care application is sent to the guarantor. It again asks the guarantor to call to make payment arrangements and warns them that the account will be referred to a collection agency if payment is not received.

g) Accounts are referred to a collection agency in no less than 30 days after the final notice letter is sent.

2. Balances after insurance are sent an initial statement showing insurance payments and adjustments, and then patient balances are collected using steps 1.b) through 1.g).

3. Statements and referral to a collection agency are put on hold when a patient applies for Summit Care. A complete application will be processed within ten business days. Incomplete applications will be kept on file for a period of 60 days from receipt as we try to obtain missing information. If the needed information is not provided within 60 days, the application will be denied and returned. The hold will be removed and collection activity will resume.

4. Accounts are taken out of Accounts Receivable and labeled as Bad Debt in the Meditech system when they have processed through our collection cycle. This enables us to create an electronic file for submission to the collection agency and efficiently manage subsequent activity, including payment reporting.

5. Mail returned as undeliverable/address unknown at any point in the collection process is outsourced to the collection agency for skip tracing. The account is moved to General Ledger Bad Debt status at the time the mail return is referred to the agency for skip tracing.

6. The third party healthcare financing company funds accounts with recourse immediately for patients with a high propensity to pay. They fund accounts after three payments have been made for patients with a low propensity to pay. Delinquent accounts are returned to the hospital after 90 days and resume collection activity at step 1.f) above by getting the statement immediately preceding the final notice letter.

7. The collection agencies send notices and make phone calls for 120 days before reporting the debt to three credit bureaus.

8. The collection agency coordinates collection activities for accounts after referral. After four years of no payment activity, accounts will be returned to the hospital as uncollectible. At that point in time, Medicare accounts are deemed uncollectible for bad debt cost reporting purposes. Accounts are documented with canned text and agency codes to indicate the cost reporting year in which

accounts were returned and reported as a bad debt to Medicare.

9. With each Medicare cost report submission, any recoveries on previously reported bad debts will be reported. Recoveries will be identified by generating a computerized report of payments on bad debt accounts that reflect Medicare insurance.

SUPPORTING DOCUMENTATION:

The Joint Commission Function/Standard: Not applicable.

Department of Health Regulation: Not applicable.

OSHA Standard: Not applicable.

Other: Medicare requires that collection efforts continue for a minimum of 120 days before considering an account a bad debt. Medicare doesn't consider an account uncollectible until it has been returned to the hospital as uncollectible and all attempts to collect the debt have ceased.

IRS section 501(r) (6) requires a 120-day notification period followed by a 120-day application period.

PATIENT EDUCATION REQUIREMENT: Not applicable.

AGE SPECIFIC REQUIREMENT:Not applicable.
Baddebtpolicy