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Title of Owner	Patient Access Center Manager
Title of Approving Official	VP Revenue Cycle UVMHN-CVMC
Date Effective	7/6/2018
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THE University of Vermont HEALTH NETWORK
Central Vermont Medical Center

TITLE: Credit & Collections For Self Pay Balances

PURPOSE: To clarify the self-pay billing, payment and collections process through established procedures for effective management of self-pay receivables ensuring a consistent and fair process for debt collection.

POLICY STATEMENT: The University of Vermont Heath Network-Central Vermont Center Medical Center (CVMC) is a patient-centered organization committed to treating all patients equitably, with dignity and respect regardless of the patient's health care insurance benefits or financial resources. CVMC has established a strong mission to meet the medical needs of the communities it services. A sound collection policy is an important and fundamental component of the mission. As such, through the billing process, with expectation of payment at the time of service and/or time of initial billing. Individuals who receive services are expected to pay for these services and/or find other means of resolution which may include health insurance coverage, an approved payment plan and/or if eligible the patient financial assistance program. When all efforts to obtain payment from the patient or sponsorship from the financial assistance program have been exhausted, accounts will be referred to a third party collection agency at the end of the billing cycle. Central Vermont Medical Center does not engage in extraordinary collection actions and makes reasonable attempts to inform, educate, and encourage patients to apply for financial assistance where hardship exists. Central Vermont Medical Center does not discriminate on the basis of race, color, sex, sexual orientation, gender identity or expression, age, language, or physical or mental disability.

PROCEDURE:

1. Central Vermont Medical Center will submit claims to insurers and will work with them to facilitate timely processing. The patient is responsible for complying with all pre-authorization, pre-certification, referral and other policy requirements. The patient's insurance policy is an agreement between the patient and the insurance carrier; it is not an agreement between the organization and the insurance carrier.

2. A guarantor system determines who is financially responsible for self-pay balances. Adults are responsible for themselves as well as their minor children. In the case of married individuals, the patient shall maintain financial responsibility regardless of who is the insurance policyholder.

3. The guarantor will be billed on a monthly cycle for all self-pay balances determined to be their responsibility. Statements will be sent after insurances have acted on the claims and/or no response has been received from the insurer. In the case of an uninsured patient, a statement will be generated after services have been rendered. Payment in full is due at time of service and/or no later than the due date on the initial billing statement.

4. The guarantor will receive a total of three statements followed by a pre-collection letter (Final Notice) over the course of 120 days. Should statements be returned as undeliverable, Customer Service will contact the patient via phone to obtain an accurate billing address. In this case, the new mailing date will begin the 120 day course of billing. If no contact can be made with the patient and payment is not received within 120 days, the account will be referred to a collection agency for follow-up. All statements indicate that financial assistance is available; the phone number to contact a Customer Service representative is also included.

5. When payment is not received, Customer Service Representatives will attempt to contact the patient within 30 days of statement mailing to obtain payment and/or establish a payment plan. If we are unable to connect with the patient, Follow-up calls via automated messaging will occur over the course of the 120 day billing cycle. Additional

messaging of increase urgency will be reflected on second and third statements with the mailing of a pre-collection (Final Notice) letter urging the patient contact the Customer Service department.

6. Patients who are unable to make payment in full may be offered a budget plan. Budget plans are a courtesy and when a patient enters into the agreement an expectation for timely and consistent payment is expected. Budget plans may be offered up to a maximum of 36 months depending upon the total account balance. Should a patient request an extended timeframe, management reserves the right to extend beyond 36 months.

7. Guarantors/Patients who are unable to make payment in full or through a budget plan shall be informed of and counseled on the Patient Financial Assistance Program. Customer Service representatives will educate and encourage the patient on how to apply for assistance and will direct patients to our website for applications to mail an application directly to the patient. At the time an application is sent to the patient, accounts in arrears will have one month of aging reduced to allow time for the patient to complete and return the application.

8. Statements include all services provided to the patient where a patient responsibility remains. Although billed in aggregate on a monthly basis, aging of individual encounters occurs independently of other services. Each encounter shall receive a minimum of 120 days of billing from the date of initial self-pay balance prior to a collection agency referral.

9. It is the patients/guarantors responsibility to update the organization with any changes in their billing address and their telephone number. Statements returned for a bad address and where a viable address cannot be obtained via phone shall remain in-house for the full 120 days. An exception to this process may occur for international patients which may have an expedited transfer to a third party follow-up agency. In cases where there is no way to contact a guarantor, the account may be sent to an outside collection agency prior to the 120 day window for skip tracking follow-up.

10. Accounts referred to a collection agency within seven days of placement, shall be recalled if payment is made, budget arrangements are established or if the patient has requested financial assistance. Note: approved financial assistance applications may have accounts recalled from the third party agency if they fall within the application window.

11. Central Vermont Medical Center does not engage in extraordinary collection actions, this includes: the selling of an individual's debt to a third party, deferring or denying or requiring a payment before providing medically necessary care because of an individual's nonpayment of one or more bills for previously provided, or care covered under the financial assistance program. CVMC may file a lien on the proceeds of a judgment or settlement to an individual as a result of personal injuries for which CVMC provided care, e.g., auto accident.

12. Central Vermont Medical Center staff will adhere to all local, state and federal collection laws and regulations regarding credit and collections. The Fair Debt Collection Practices Act is the current standard.

13. Accounts placed in collections will remain with the collection agency for a period of 2.5 years with no activity. But may be recalled sooner or left longer at the decression of management

MONITORING PLAN: Sample auditing of accounts; system generated transaction based processing of aged accounts; routine review of transaction reports, statement edits and reconciliation of collection accounts.

DEFINITIONS: CVMC Central Vermont Medical Center

RELATED POLICIES:

Patient Financial Assistance A-119

REFERENCES:

Fair Debt Collection Practices Act
IRS 501r

REVIEWERS:

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