

Central Vermont Medical Center

**Title: Credit and Collections for Self Pay Balances**

**Purpose:**

Central Vermont Medical Center (CVMC) is committed to providing medically necessary care to all patients regardless of their ability to pay for these services. Individuals and families who have received services from Central Vermont Medical Center are obligated to pay for these services, and/or find other means of resolution. Satisfaction of debts incurred by guarantors will be determined by the guarantor's financial status, the organization's ability to accept payment plans, and the guarantor's cooperation.

Central Vermont Medical Center will not discriminate in the resolution of the guarantor's obligation on the basis of race, color, creed, sex, age, or handicap.

**Policy Statement:**

Payment for services provided by Central Vermont Medical Center is due in full at the time of service. The organization may defer payment to submit claims to insurers, and will work with them to facilitate timely processing. The organization will submit claims to insurers and facilitate timely payment for its services wherever possible. Payment penalties assessed by the patient's insurer applied as their obligation to the hospital, practices or nursing home is the guarantor's responsibility. The guarantor is responsible for complying with all pre-authorization, pre-certification, physician referral, and other policy requirements. The patient's insurance policy is an agreement between the patient/guarantor and the insurance carrier; it is not an agreement between the organization and the insurance carrier.

CVMC (Marcam) billing staff will adhere to all local, state and federal collection laws and regulations regarding credit and collections. The Fair Debt Collection Practices Act and the 501r regulations are the current standard.

The organization utilizes a guarantor billing system. Adult patients will be responsible for themselves, as well as their minor children. To comply with HIPAA privacy standards, married couples will maintain separate guarantor status. Statements will be sent after insurances have acted on the claims, or if there is no response from the insurance company after a reasonable time. If there is no insurance, statements are sent as soon as the charges have been entered and the account has been finalized.

Each guarantor will be sent an itemized first statement and a combined statement going forward unless we receive returned mail with no forwarding address. We will also attempt to contact the guarantor by telephone if the bill is not paid within 30 days of the first statement mailing. All statements indicate that financial assistance is available, and the phone number to contact a financial counselor is included.

After 120 days from the date of the first statement billing the account will come up for review for placement with our collection agency. If the patient does not pay the account in full, set up a monthly payment plan, or apply for financial aid or other state program, the balance may then be sent to our collection agency or attorney. We may file a property lien against attachable assets in order to secure our interest.

Guarantors who are identified by the organization as potentially eligible for our Financial Assistance program will be encouraged to apply. Guarantors may also initiate and request consideration for the Financial Aid program by requesting an application from the organization. The program is administered by the Patient Financial Services Department in accord with the organization's Financial Aid policy (A-119).

Payment plans must be agreed upon by both the organization and the guarantor, and will not be considered in effect until the patient makes the agreed-upon initial payment. An arrangement has not been made if a guarantor makes partial payments without notifying the organization of his/her intention. All payment plans are offered by the organization as a courtesy and are based on the organization's ability to provide such arrangements. The organization is under no obligation to extend credit arrangements. If a guarantor misses a scheduled payment, the account will be considered to be in default and this will result in further collection action.

All guarantors have the right to a summary or itemized copy of their bill(s), except where disallowed by law.

Obligations involving attorneys or third party liability may be held from collection action if the organization has filed a lien, the attorney or third party provides an unconditional written guarantee, or arrangements are made to resolve the debt. The organization reserves the right to advise primary health insurance payers of third party liability. Liens may be filed as allowed by law.

It is the guarantor's responsibility to update the organization with any changes in their billing address and their telephone number.

The organization reserves the right to secure their debt through legal means allowed by law. Accounts that come up for placement in collections will be reviewed for referral to our collection attorney. Prior to placement with our attorney we will send a letter to the guarantor to advise them that we are considering placement. Our HAP financial assistance policy summary and an application for assistance will be included with the letter. They will be informed that placement could result in referral to the Credit Bureau and other legal action, including a lien on their property. We will also inform the guarantor of our payment plan option.

The guarantor will be given 30 days from the date of the letter to respond by submitting a HAP application or by contacting us to make payment arrangements. If there is no response within 30 days the account will be sent to our collection attorney.

Our collection attorney will refrain from placing with the Credit Bureau or other legal actions for 90 days from the date the account was sent to them. If the patient applies for HAP assistance during this period, collection action will be suspended pending determination of eligibility for assistance.

If the patient is found to be eligible for assistance, the account will be removed from our collection attorney. Assistance will be applied, and any balance due will be billed to the patient.

Payment arrangements for the balance after assistance will be handled by CVMC.

If no payment is made after assistance is applied, or if the patient defaults on the payment arrangement, the account will be sent back to our attorney or to our collection agency.

If the patient is found to be ineligible for assistance the account will remain with the collection attorney to follow-up on payment arrangements, credit reporting, or other legal action to obtain payment.

## **Procedure:**

1. Guarantors shall be billed for balances which are determined to be their responsibility. This determination will be made according to the following standards:
  - A. There was no insurance coverage for services rendered.
  - B. Insurance was billed and the entire balance was not satisfied by the insurer because the patient had out-of-pocket expenses (co-payment, co-insurance, deductible, and cost-share) to be satisfied in accordance with their insurance policy provisions.

- C. Insurance was billed and the entire balance was not satisfied by the insurer because the patient did not comply with the insurance policy requirements.
- D. Insurance was billed and the entire balance was not satisfied by the insurer because the services provided were not covered under the patient's policy.
- E. Insurance was billed, but the insurance carrier does not respond in a timely manner.
- F. The guarantor refuses to accept a reasonable settlement offer which includes payment for our services (ex: Third Party Liability claims).

Once the self-pay balance has been determined, monthly statements will be generated to inform the guarantor of their obligations to the organization and to request payment.

- 2. Unless statements are returned due to an incorrect address, a minimum of four statements will be sent to the guarantor for each account before the account is eligible for bad debt write-off and assigned to a third party collection vendor. Accounts in excess of \$500 with incorrect addresses will be researched to obtain a correct address, and attempts will be made to contact the guarantor by telephone prior to referring them to collections. Billing of deceased patients will continue as with other patients unless it is established that the patient left no estate or that available estate funds have been exhausted.
- 3. Guarantors who wish to establish a monthly payment arrangement must contact the organization to request one. Both the organization and the guarantor must agree on the terms of payment. Failure to abide by the terms of payment will result in referral to a third party collection vendor. (*See Attachment I: Payment Arrangement Processes and Procedures*)
- 4. Third party liability and litigation accounts are to be considered as the guarantor's responsibility. Guarantors will be billed and the accounts moved to bad debt if no written guarantee is received from the guarantor or third party, no arrangements are made, no letter of protection is received from the guarantor's attorney, or payment in full is not received. The organization reserves its right and responsibility to report third party liability to primary medical insurance carriers. The organization may utilize its collection attorney to secure its interests in any settlement. The organization shall file liens as allowed by law.
- 5. Accounts will be referred to bad debt if the guarantor is uncooperative, the organization's interests are unsecured and in danger of being lost, acceptable arrangements have not been made, arrangements are in default, or if the debtor cannot be reached by mail or telephone. The categories of write off are as follows:
  - A. Medicare Bad Debt
  - B. Non-Medicare Bad Debt
  - C. Uncollectible – Bankrupt, Deceased with no estate, not billable.
- 6. Settlement on obligations will be considered on an individual basis. The guarantor's circumstances, the organization's debt, the likeliness of receiving payment in full and other concerns will be considered. The Financial Counseling Team Lead is responsible for negotiating and approving all offers up to \$5,000 in loss. The Director of Patient Access will negotiate and approve all offers up to \$10,000 in loss. The Chief Financial Officer will approve all losses in excess of \$10,000. CVMC will offer a 30% prompt pay discount for charges for which no insurance coverage is available and a 10% discount for patient balances after insurance payments and adjustments. Prompt payment means payment of the agreed-upon amount within 10 working days from the time we offer a discount to the guarantor.
- 7. Responsibility for determining the guarantor for an account will be based on the Guarantor Assignment Policy. The organization's position on divorce decrees is that the guarantor is the person who received the service or the parent who brings the child in for services and signs the consent (not the subscriber of insurance). The organization cannot enforce divorce decrees since they are an agreement between the divorcing parties and the court system.

8. Payment for cosmetic services or services which are not medically necessary is due on or before the day services are provided. Exceptions must be approved by the Director of Access or Administration.
9. All collection activity prior to referral to an outside collection agency or attorney will be documented in the account notes.

Cross Reference Policy #(s): A-119 Financial Assistance Plan

## **Attachment I**

### **Payment Arrangement Process and Procedures**

Payment arrangements allow patients to pay their hospital and physician charges over an extended period of time when they are unable to pay the balance in full due to their financial situation. Central Vermont Medical Center and Medical Group Practices does not currently charge any interest on payment arrangements. All patients can establish payment arrangements subject to certain conditions. All requests for employee payroll deduction payment arrangements should be referred to one of the Financial Counselors. Normally, we will not establish a payment arrangement until we have received the first payment. If there has been no formal agreement as to payment amount, patients who are paying accounts on a monthly basis may be subject to referral to a collection agency.

#### **Eligible Accounts**

Accounts are eligible for payment arrangements if:

The account is in final bill self-pay status.

The patient has been sent at least one statement.

Accounts in bad debt status are not eligible for payment arrangements. Payment for accounts placed with collection agencies should be made directly to the collection agency. When determining the total balance due, we will include all accounts for that guarantor in the final bill self-pay status for which they have received a statement. New balances due after the establishment of the PPA can be included but the guarantor must be informed and agree to include the new accounts in the PPA. Accounts with different guarantors in the same family may be included in the same PPA. Accounts for family members will be combined to an account for the guarantor requesting the payment plan.

#### **Payment Amounts**

The minimum monthly payment for accounts under \$1000.00 is \$35.00 per month. For balances over that amount, the monthly payment amount is calculated by dividing the balance due by 36 months. Payments made in excess of the established monthly payment can be made at any time, but the agreed-upon monthly payment must be made every month (i.e. there is no paying in advance).

Large dollar accounts that are considered a financial hardship (due to household/medical expenses) will be reviewed for special arrangements. Requests for exceptions to the minimum payment amount should be reviewed with the Financial Counseling Team Lead. We may require that the guarantor submit a completed Financial Assistance application and/or documentation of income and expenses before making a decision on a lower payment amount.

#### **Payroll Deductions**

CVMC employees who wish to use payroll deduction may do so by completing the Payroll Deduction Authorization form and returning to the Financial Counseling Office. Payroll deductions are treated as any other Payment Plan Arrangement with regard to policy and procedures.

A copy of the Payment Plan Letter 1 should be attached to the Payroll Deduction Authorization. This form is to be submitted to the accounting department to begin the payroll deductions.

#### **Due Dates**

1. If the patient does not make the first payment at the time of request for a payment arrangement, a first payment due date should be firmly established.
2. The patient should be informed that the payment arrangement will not begin until the first payment is received.

3. The due date should be between 15 and 30 days from the date the agreement is established. The start date, due date and payment amount should be entered in Meditech using the “E/E Guarantor Contract” routine (#41).
4. The patient should be advised of the due date at the time the agreement is established and that payment is to be made every month by this date or the Payment Plan Arrangement will be terminated.

### **Written Notification & Reminder Letter (Old Statement Vendor Procedure)**

Upon receiving an initial request for a payment arrangement, the Financial Counselor will confirm that the first payment has been made and set up the arrangement in Meditech to notify our statement vendor. If the first payment has not yet been made, the Financial Counselor will set up a reminder in Meditech for the first payment due date, then set up the payment arrangement once the first payment has been received. Our regular statement letters continue if the first payment is not received by the agreed upon due date. Once the payment arrangement is established our statement vendor will send a reminder notice to the patient 20 days prior to the due date. Our statement vendor will notify us of a default if the payment is not received within 15 days after the due date, and stop sending reminder notices.

### **Marcam (Statement Provider) Contacts/Notification/Follow-up**

Marcam will often be the first to discuss payment arrangements with guarantors. They will discuss the payment amount and due date in accordance with this policy, set up arrangement and notify us of the terms. Requests for exceptions to our policy will be referred back to the Financial Counseling Team Lead. Marcam will notify us of the Payment Plan Arrangement, and we will set up the Payment Plan Arrangement in Meditech. Marcam will then send monthly reminder letters to the guarantor and let us know of payment defaults.

### **Defaults**

Guarantors who miss their required payment will be sent notification of the default informing them that two payments are due by the next due date. If they do not make this required payment, a final notice (Payment Plan Final Notice) will be mailed asking for three payments by the next due date to bring the account current. We may also make telephone contact with the guarantor to discuss bringing the account current. If the account is not brought current or other arrangements made prior to the final notice due date it may be referred to our collection agency.

### **Posting Payments**

Payment should be posted to the oldest outstanding balance on the payment plan. Once that account has been paid in full the contract should be terminated. The patient must establish a new contract for any additional accounts. Payments received after the contract has been terminated should be posted to the oldest active guarantor account (not bad debt accounts) unless the patient indicates a specific account number for the payment.