Montefiore

SUBJECT: Billing and Collection Policy:
Bad Debt Referrals Procedure NUMBER: JF31.1

OWNER: Revenue Cycle

EFFECTIVE	REVIEW/REVISED	SUPERSEDES:
07/15	11/22	7/15, 9/16, 9/19, 11/19, 7/20, 6/22

CROSS-REFERENCE: Financial Assistance Policy JF14.1, Self-pay follow up policy (JF26.1) and Payment Plan Procedure (JF27.1)

PURPOSE:
To relieve the Accounts Receivable (AR) of accounts deemed uncollectible by internal or external pre-collection processes. Montefiore Medical Center (MMC) 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.

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

SCOPE:
MMC associates responsible for collection of self-pay balances. This policy will apply to all MMC departments, units, divisions and associates, inpatient, outpatient diagnostic and treatment centers.

DEFINITION(S):
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.

PROCEDURE:

Financial Aid - If the patient requests financial aid, they should be referred to the financial aid office in accordance with the financial aid policy

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 payment arrangement guidelines. Refer to payment plan policy.

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

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

- Account is self-pay and has been billed and remains unpaid for over 120 days and all reasonable collection efforts have been exhausted (including but not limited to):
    1. Four (4) Self Pay statements have been sent. Statements are sent at 30-day intervals. A pre-collection/past due letter will be sent out in conjunction with the final statement.
    2. A review of previous accounts is performed in the billing systems to determine if a valid third-party payer exists for date of service.
    3. A name search is performed for Medicaid via eligibility portal(s) to determine if patient has Medicaid coverage.
- Patient/Guarantor advises MMC associate that they have no intention of paying the bill.
- Patient communication via mail and/or phone is unsuccessful due to incorrect information. An attempt will be made to obtain correct/updated address before account is referred.
- Patient defaults on payment plans via Loan program.

*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.

- Bad debt write offs are divided into two categories: Medicare Bad Debt and Bad Debt. In order to qualify for Medicare Bad debt, the balance due must be the Part A Deductible, Coinsurance or Lifetime reserve days due from the patient. Medicare Bad Debt also refers to the 20% Part B patient responsibility for outpatient services.
- International patient accounts returned by International Collection agency will be adjusted as bad debt once international agency closes out. International patient accounts will not be referred to secondary agency.
- There are certain instances where at the discretion of MMC an account will be adjusted as bad debt without going to an agency. For example:
    1. John/Jane Doe accounts.
    2. Prior accounts which have recently been returned from primary/secondary as uncollectable.
    3. If accounts fail the system action (or associate fails to complete the transfer on manual referrals) and do not move from primary agency to secondary agency after primary closes out account and there is a gap from when primary closed and failure discovered the account may be written off without going to a secondary agency.

The year- end final bad debt report is reviewed and signed by the Senior Director of Patient Financial Services and the VP/CFO.

Self-pay patients must always receive a bill prior to being referred to a collection agency unless there is a bad address on file. All efforts should be exhausted to locate a correct address.

Daily electronic referral files are sent to the bad debt agency. Accounts may also be referred to collection by adding an account activity to send to the respective agencies.

Accounts may also be referred to collection by changing the dunning levels. If an associate determines that an account should be referred immediately to collection, the dunning level will be changed. The associate will code the account accordingly and the system will automatically transfer the account to the appropriate collection agency. Associate will discuss with a Manager/Supervisor, any accounts with a balance over $25,000 before referring the account to collections and the Manager will approve such accounts and note systems accordingly.

Any inquiries received within 30 days of the primary 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.

Any patient inquiries received after 30 days of a primary agency referral will be referred to the agency. Payments should always be processed by internal staff when patient requests to pay.

Any payments recovered from the agency are sent to MMC with a remittance advice and will be posted to the account as "Collection Agency Payment".

A request to recall an account from the agency may be received for but not limited to:

- Accounts paid prior to bad debt referral but payment was not posted
- Misapplied payments
- Patient never had services (must be confirmed)
- Patient disputes charges (must be confirmed)
- Administrative Reasons/Patient Relations Issues
- Unapplied Allowances
- Special Programs (i.e. NYC Child Health Programs)
- Risk Management
- Financial Aid
- Insurance was found and verified

Requests to recall an account from the agency are made via adding EPIC billing indicator 222. The agency receives daily files of withdrawals/recalls so they can close out account on their end. (A note will be entered indicating reason for withdrawal).

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. This verbiage is also shown on self-pay statements and the pre-collection letter (past due self-pay letter). Collection agencies affiliated with the hospital must follow the same guiding principles.

Self-Pay accounts returned from external collection agencies as uncollectible will be written off with the Bad Debt. If the external collection agency deems a patient as deceased, they will perform an estate check for balances greater than $1300. Deceased balances below this threshold will also be written off as Bad Debt.

Any Medicaid or Medicaid Managed Care secondary insurance balances after Medicare which denies

indicating that the primary paid more than the allowed amount, will also be written off as Bad Debt.

Financial aid shall be available to:

- Uninsured patients residing in the Medical Center's primary service area receiving medically necessary services or emergency care (refer to Financial Aid Policy JF14.1)
- Patients residing in the Medical Center's primary service area that exhausted their medical benefits for medically necessary or emergent care.

Except for emergency services, patients must reside within the Medical Center's primary service area for a particular service to be categorically eligible for financial aid. The Medical Center's primary service area is New York State. Patients residing outside of New York State that receive emergency care are eligible for financial assistance.

Eligibility for financial assistance for non-emergent care for non-residents of New York State will be determined on a case-by-case basis and requires Vice President Approval. If patient is approved to receive financial assistance as an exception, they will be screened using same criteria as patients residing in the primary service area (gross income and family size tied to federal poverty level).

Elective procedures that are not deemed medically necessary (e.g. cosmetic surgery, infertility treatment) are not eligible for financial aid. Patients can obtain a self-pay discount for non-covered services.

Primary Collection Agency Steps: Once an account is referred to the Primary Collection agency, the company will follow their internal process to identify active Medicaid insurance, address and telephone verification and return mail.

- At least 1-4 letters sent
- At least 1-4 telephone calls made
- Accounts with mail return and no phone number are closed and returned to MMC for referral to secondary collection agency
- Accounts with no activity will be closed and returned 180 days from referral date for referral to secondary collection agency
- Estate searches and Bankruptcy Scrubs may also take place

If an account is returned by primary collection agency it will be determined if the account should be closed and written off as bad debt or if it should be referred/transferred to a secondary agency based upon the return reason code. All activity will be documented within the system.

Secondary Collection Agency Criteria -_Accounts with balances $19.99 and under will be written off as terminal bad debt upon return from primary agency. Balances $20 and over will be referred to a secondary agency.

Secondary Collections Steps - Once an account is referred to the Secondary Collection agency, they will go through their internal processes looking for active insurance, address and telephone verification and a return mail process. In addition, credit inquiries and estate 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
- Accounts with mail return and no phone number are closed and returned to MMC for write-off.
- Accounts 180 days from referral date are to be closed and returned to MMC for write-off unless patient is actively paying on an account or agency is pursuing an estate for payment.

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Both primary and secondary agencies can negotiate settlements on outstanding patient liability.

Montefiore medical Center does not engage in the following "Extraordinary Collection Actions":

- Report adverse information to credit agency
- Defer or deny, or require payment before providing, medically necessary care because of an individual's nonpayment of one or more prior bills for services covered under the Financial Assistance Policy.
- Place a lien on an individual's property (excluding certain liens related to a patient's suit against a third party responsible for a patient's injuries)
- Foreclose on an individual's property
- Attach or seize an individual's bank account or any other personal property
- Cause an individual's arrest
- Cause an individual to be subject to a writ of body attachment
- Garnishing an individual's wages

Each collection agency is required to send a detailed month end statement inclusive of all account payments with patient detail.

Accounts with balances $19.99 and under will be written off as terminal bad debt upon return from primary agency. Balances $20 and over will be referred to a secondary agency.

Pandemic Protocol:
If a patient expresses hardship due to loss of job or source of income during a pandemic, an account can be placed on hold for up to 90 days. Once the hold is released, the dunning will be reset to level 1 and billing resumed.

Approved by:

C. Ellen Blye

Colleen Blye
Executive Vice President, CFO