



Patient Financial Services Policy and Procedure Manual

Category/Section: Collection & Bad Debt

Policy Number: PFS-007

Title: Collection/Bad Debt

Policy Origination Date: April 1, 2014

Policy Revision #: 4

Last Date Reviewed: 11/29/2024

Effective Date of Current Revision: November 29, 2024

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POLICY:

St. John's Episcopal Hospital is committed to assuring that after exhausting all reasonable follow-up efforts (including but not limited to financial screening), unpaid Self-Pay claims are referred to external agencies for further collection efforts and the account classified as bad debt.

PURPOSE:

The purpose of this policy is to identify St. John's Episcopal Hospital's process for referring accounts to collection/bad debt.

ATTACHMENTS:

None

DEFINITIONS:

1. **Self-Pay** – Refers to accounts with patient balances where the patient or guarantor is responsible for the balance as patient has no insurance, has a responsibility assigned by the insurance carrier, or due to insurance denials for which the patient is liable (i.e.: not responding to insurance questionnaires related to coordination-of-benefits, accident information, etc.).
2. **Bad Debt** – Refers to balances submitted to a third-party payer or patient/guarantor, which is not paid in full for various reasons, and unlikely to be paid.

RESPONSIBILITIES:

1. **Sr. Revenue Cycle Analyst and/or Designee** – Will set up processes, with Revenue Cycle's management input, for referring Self Pay balances for insurance discovery and/or presumptive charity care eligibility to designated vendors.
2. **AP/AR Clerk and/or Management** – Will review accounts under hospital system(s) to determine any applicable billable insurance when reviewing Self-Pay accounts, identify accounts for vendor recall based on criteria delineated in this policy, and document hospital system(s) at the account level.
3. **Management and/or Designee** – Will review accounts and approve account recall from applicable vendor, and document hospital systems(s) at the account level. They will also



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review accounts returned by the collection agencies/vendors for bad debt closure to validate such closure and/or potential secondary referrals.

4. **Collection Agencies/Vendors** – Will ensure that collection patient statements/letters advise the patient of potential eligibility for financial assistance pursuant to our Charity Care/Financial Assistance Policy.

PROCEDURES/GUIDELINES:

1. An account may be referred to collection / bad debt if it meets one or more of the following criteria:
 - a. Self-Pay balance not paid within 120 days after bill date when all reasonable follow-up efforts have been exhausted.
 - b. Patient/Guarantor advises Patient Accounts team member that they have no intention of paying the balance.
 - c. Patient communication via mail, other authorized forms of communication, and/or telephone is unsuccessful due to bad information and/or is not responded to by patient/guarantor.
 - d. Patient fails to meet agreed payment plan, at which point the billing system moves the account to the next phase of billing in order to meet the required number of statements (four) prior to transfer to collection/bad debt.
2. If a Self-Pay account that has been billed remains unpaid for over 120 days and all reasonable collection efforts have been exhausted, the account will be referred to bad debt. Reasonable collection efforts include:
 - a. Sending an initial Self-Pay bill (statement) for the balance and subsequent statements at 31 days, 61 days, and 91 days from bill date.
 - b. Reviewing previous accounts in the hospital's billing system to determine if a valid third party payer exists for the particular date-of-service.
 - c. Self-Pay "sweeps", via the established vendor, to determine Medicare and/or Medicaid eligibility as well as any managed care plans linked to said coverage.
3. There are three types of Medicare patient balances that can be classified as Medicare bad debt (see below).
 - **Note** that prior to referring a Medicare patient balance to bad debt, the reasonable collection efforts identified above (see item #2) must have been met, or one or more criteria under item #1 above.
 - Co-insurance (Inpatient/Outpatient)
 - Deductible (Inpatient/Outpatient)
 - Life Time Reserve Days {LTR} (Inpatient)
4. Any inquiries received within 10 days of the 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.

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5. Any patient inquiries/payments received after 10 days of an agency referral will be referred to the agency for documentation in their respective systems and documented in the hospital system(s).
6. Payments recovered via the agency are sent to facility with a remittance advice and will be posted to the account; the hospital billing system will classify the payment as “Bad Debt Recoveries” based on the “BD” assignment in the receivable system.
7. A request to recall an account from the agency may be received for:
 - a. Account paid prior to bad debt referral, but payment was not posted
 - b. Misapplied payments
 - c. Patient never had services (must be confirmed)
 - d. Patient disputes charges (must be confirmed)
 - e. Administrative Reasons/Patient Relations Issues
 - f. Unapplied Allowances
 - g. Risk Management
 - h. Financial Assistance
 - i. Insurance was found and verified by Patient Financial Services team members
8. Requests to recall an account from the agency will be referred to the appropriate management personnel and/or designee, in Patient Accounts, and will indicate the reason for the request. Management will approve or deny the request:
 - a. Approved – Account(s) must be reversed from bad debt and transferred back to “FB” status; a detailed note entered indicating the reason for recall; and the management personnel and/or designee will send the agency a secure email recalling the account, as well as notifying the requestor.
 - b. Denied – Accounts will remain in “BD” status; a detailed note entered indicating the reason for recall denial; and the requestor will be notified.
9. Collection Agencies are required to indicate on their collection letters that the patient may be eligible for financial assistance pursuant to our Charity Care/Financial Assistance Policy.
 - **Note:** All primary Self Pay accounts (with a valid Social Security #) are electronically screened, prior to referral to bad debt, for “Presumptive Charity Care Eligibility” and applicable charity adjustment applied based on financial information secured by the vendor conducting the presumptive charity care screening. Consequently, the balance referred to collection for primary Self-Pay accounts (with a valid Social Security #) already reflects the presumptive charity care adjustment.
10. If an account is returned by a collection agency with a status of “all collection efforts exhausted”, Patient Financial Services’ management and/or designee will determine if the account should be closed and allowed to zero or manually referred/transferred to a secondary agency. All activity will be documented with a note to the account, in the hospital billing system.

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11. Primary & Secondary Collection Agency

The assigned collection agency, upon account referral, will go through their internal processes to identify active Medicare, Medicaid or Third-Party Insurance, address and telephone number verification, as well as a return mail process. In addition, credit reports and asset searches will be conducted by the agency where applicable. Upon completion of this process, the following collection efforts will be made:

- a. At least 1 – 4 letters sent
- b. At least 1 – 4 telephone calls made
- c. Deceased and Bankruptcy patient accounts will be returned for write-off
- d. Accounts with mail return and no valid telephone number are closed and returned to the facility for referral to the appropriate “returned mail” collection agency
- e. Accounts in active collections 180 days from referral date are closed and returned to the facility for referral to other agencies or write-off as determined by Patient Financial Services’ management
- f. Accounts, which qualify for legal action (judgment filing), are sent to the Vice President of Revenue Cycle Management, at the facility, for approval prior to proceeding with such action. Accounts will remain open with the agency until court proceedings are completed.
 - **Note:** At no time should any lien be placed on any property classified as the patient’s/guarantor’s primary residence.

RELEVANT REFERENCES:

None

RELATED POLICIES:

Charity Care & Financial Assistance – See Revenue Cycle (Patient Accounts) respective policy.

LIST OF REVISIONS:

Revision No.	Date of Change	Additions/Amendments
1	06/17/2019	Updated “Last Date Reviewed” and “Effective Date of Current Revision” to reflect 6/17/2019 & 7/1/2019 respectively. Relabeled “Procedure” to read “Procedures/Guidelines”. Added “Responsibilities”, “Related Policies”, and “Title, Policy Owner” sections. Item #5 was revised to include “for documentation in their respective systems and also documented in the hospital system(s)”. Item #8, 8a, & 10 were revised to include “and/or designee”. Item #9 was revised to include “(with a valid Social Security #)”
2	08/05/2021	Updated policy to the New SJEH Policy Template, revised policy format. Updated owner and approver’s title
3	04/22/2022	Updated owner’s title
4	03/29/2024	Updated owner’s and approver’s titles and new EHS Logo
5	11/29/2024	Updated manual name from “Revenue Cycle” to Patient



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		Financial Services, “Policy Number: RC-007” to PFS-007, “Policy Revision#” from 4 to 5, “Last Date Reviewed:” and “Effective Date of Current Revision” from 03/29/2024 to 11/29/2024, “staff” to team members, under Procedures/Guidelines item# 1c – added “other authorized forms of communication”, “Patient Accounts” to Patient Financial Services’, “Assistant Vice President of Revenue Cycle” to Vice President of Revenue Cycle Management, and updated policy owners.
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TITLE, POLICY OWNER:

Vice President of Revenue Cycle Management
Senior Director of Revenue Cycle Operations & Systems

RECOMMENDED/APPROVED BY:

Executive Vice President & Chief Financial Officer

DISTRIBUTION:

- ☒ Nursing Staff
- ☒ Medical Staff
- ☒ Department Heads
- ☒ All Employees
- ☐ Other _____