PennState Health

Patient Credit and Collections Policy	RC-002
Penn State Health Revenue Cycle	Effective Date: **October 1, 2022**

SCOPE AND PURPOSE *The document is applicable to the people and processes of the following Penn State Health components specified below:*

X	Penn State Health Shared Services		Penn State College of Medicine
	Milton S. Hershey Medical Center		Medical Group – Academic Practice Division
	St. Joseph Medical Center		Medical Group - Community Practice Division
	Holy Spirit Medical Center		Penn State Health Life Lion, LLC
	Hampden Medical Center		
	Lancaster Medical Center – effective 10/3/2022		

POLICY STATEMENT

To provide clear and consistent guidelines for conducting billing, collections, and recovery functions in a manner that promotes compliance, patient satisfaction, and efficiency. Through the use of billing statements, written correspondence, and phone calls, Penn State Health (PSH) Revenue Cycle Department will make diligent efforts to inform patients/guarantors of their financial responsibilities and available Financial Assistance options, as well as follow up with patients/guarantors regarding outstanding accounts while ensuring transparency during the financial continuum of care. This policy is compliant with the requirements outlined in Section 501(r) of the Internal Revenue Code and the "No Surprises Act" included in the Consolidated Appropriations Act, 2021.

Applies to Registration, Billing Staff and Financial Counselors

DEFINITIONS

Amount Generally Billed (AGB) Definition: The AGB or limitation on gross charges is calculated by PSH using lookback methodology in accordance with the IRS 501R final rule. PSH will utilize this methodology to calculate the average payment of all claims paid by private health insurers and Medicare. Eligible individuals will not be charged more than the amounts generally billed for emergency or medically necessary care only. PSH will make available a free written copy of the current AGB calculation to patients who request so. This shall not be confused with the charity care (financial assistance) discount which is applied at 100% if the individuals FAP is approved.

Agency Placement: Outside collection agencies are retained to collect accounts in a Bad Debt status. When an account is in Bad Debt status, it has not been deemed uncollectible until nine months of unsuccessful collection activity with a primary or secondary collection agency has occurred.

Balance Billing – Surprise Bills: In accordance with federal legislation, the No Surprises Act, Penn State Health is committed to protecting patients from receiving surprise bills, which

patients would receive if the Penn State Health facility or provider they get care from is out-of-network for their health plan. When an out-of-network provider or facility bills patients for the difference between what their health plan agreed to pay and the full amount charged by an out-of-network provider or facility for a service, this is known as “balance billing.” “Surprise bills” are unexpected balance bills. The No Surprises Act protects patients from receiving a higher bill when seen for emergency care from an out-of-network provider or facility, or when an out-of-network provider treats the patient at an in-network hospital. If a Penn State Health facility or provider is out-of-network, Penn State Health will not balance bill for covered emergency services or post-stabilization services.

Billing Statement or Statement: A bill for services rendered. This can be a summary of activity or a detailed bill, listing each charge on a patient account.

Date of Service (DOS):

- Inpatient DOS – the date the patient is discharged from the hospital.
- Outpatient/Ambulatory DOS – the date the procedure is performed or the patient receives medical care.

Diagnostic Services – Services or procedures that are used to determine the cause of an illness or disorder. Diagnostic medical care involves treating or diagnosing a problem a patient is having by monitoring an existing problem, checking new symptoms or following up on abnormal test results. Diagnostic Services provide health care providers with the severity or cause of diseases in patients.

Elective Services or Procedures – Services or procedures that are not medically necessary, as determined by the PSH medical staff.

Emergency Medical Condition – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergent Care: Care provided to a patient with an emergent medical condition, further defined as:

- A medical condition manifesting itself by acute symptoms of sufficient severity (e.g., severe pain, psychiatric disturbances and/or symptoms of substance abuse, etc.) such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
  - Placing the health of the patient (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or
  - Serious impairment to bodily functions, or
  - Serious dysfunction of any bodily organ or part.
  - With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or her unborn child.

Guarantor: The person who is financially responsible for a patient's bill. In the case of an adult or an emancipated minor, the patient will generally be his/her own guarantor. Children under the age of 18 will generally not be listed as the guarantor. All services rendered to a minor will be billed to the custodial parent or legal guardian, unless the minor is emancipated.

Medically Necessary: Shall mean health care services that a provider, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

- In accordance with generally accepted standards of medical practices
  - For the purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgement.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
- Not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
- Services, items or procedures considered investigational or experimental will be addressed on a case by case basis.

Non-covered or Experimental Services or Procedures – Services or procedures that are established as:

- Experimental/Investigational Services or Procedures – Medical services, procedures or drugs that have not been approved for general use but are under investigation in clinical trials regarding safety and efficacy. Experimental and investigational services, procedures, or drugs are intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease.
  - As the treatment protocols are developed for experimental and investigational services, PSH Revenue Cycle Department will work with the payer community to explain the medical necessity.
- Non-covered Services or Procedures – Medical services or procedures that are not covered by the patient's insurance plan.

Patient Responsibility: Any balance due where the financially responsible party is the patient or the patient's guarantor (not a third party payer).

- Delaying of Care – PSH may delay non-emergent services or procedures for those patients repeatedly refusing to establish reasonable patient responsibility efforts for care provided, care provided under the EMTALA policy are excluded.

Primary or Specialty Care Services – Services or procedures provided to patients who arrive to the hospital seeking non-emergent or non-urgent medical care or seek additional care following stabilization or an emergency medical condition. Primary or specialty scheduled services are either primary care services or medical procedures scheduled in advance.

Urgent Care: Care provided to a patient with a medical condition that is not life/limb threatening or not likely to cause permanent harm, but requires prompt care and treatment, as defined by the Centers for Medicare and Medicaid Services (CMS) to occur within 12 hours, to avoid:

- Placing the health of the patient in serious jeopardy or to avoid serious impairment or dysfunction; or
- Likely onset of an illness or injury requiring emergent services, as defined in this document.

POLICY AND PROCEDURE STATEMENTS

PSH will pursue payment on patient accounts consistently, regardless of race, primary language, gender, age, religion, education, employment, student status, disposition, relationship, insurance coverage, community standing, or any other discriminatory differentiating factor.

Every patient/guarantor will be given a reasonable time frame and communications to understand his/her financial responsibility. PSH will seek to notify patients/guarantors of their financial responsibility in advance of their service in non-emergent situations. PSH may postpone or cancel non-emergent care (as determined by PSH medical staff) for any patient who is unable or unwilling to be financially cleared prior to an elective service. Patients will be provided an opportunity to apply for financial assistance in accordance with the **Financial Assistance Policies - PFS-051/PFS-053.**

Financially cleared will be defined as cooperating and completing with all processes necessary to ensure an exception-free financial continuum, including but not limited to:

- Proof of insurance
- Correct demographic information
- Payment of all applicable out of pocket expenses (i.e. co-pay, coinsurance, deductibles, and non-covered charges).
- Working with PSH Financial Counselors to attain third party benefits or financial assistance.
- Resolving outstanding patient balances for previous PSH health care services.

Failure to provide the necessary information for financial clearance to PSH could result in the individual's account being forwarded to an outside collection agency for further collection on balances.

Insurance Billing:

The patient's medical insurance coverage constitutes a contract between the patient, the insurance provider and/or the patient's employer. Penn State Health is not a part of this contract. PSH will when applicable comply with the No Surprises Act.

Patients are responsible to:

- Know if a referral is necessary for office visits.
- Check with their insurance provider to determine if prescribed testing is covered under their medical coverage policy.

- Contact the insurance provider to determine the schedule of benefits and if a co-payment or deductible applies.
- Receive and/or sign the No Surprises Billing Notice and Consent Form.
- Arrive for appointments with proper documentation.
- Work with our business office to appeal adverse determinations.

Following the provision of care, every reasonable attempt will be made to process a patient's claim through his/her provided insurance or third-party payer (based on information provided by or verified by the patient/guarantor, or appropriately verified from other sources) in a timely manner.

- If an otherwise valid claim is denied (or not processed) by the payer due to an error by PSH, PSH will not bill the patient for any amount in excess of what the patient would have owed had the payer paid the claim.
- If an otherwise valid claim is denied (or not processed) by a payer due to factors outside of the PSH's control, staff will follow up with the payer and patient as appropriate to facilitate resolution of the claim.
- If resolution does not occur after reasonable follow-up efforts, PSH may bill the patient or take other actions consistent with payer contracts.

Patient Billing:

Any balance after adjudication of an insurance claim from the payer will be billed to the patient (or guarantor) based on the explanation of benefits.

In the absence of a third-party or insurance payer, patients will be billed directly. These patients will be considered to be self-pay patients. PSH shall not charge uninsured FAP eligible or non-FAP eligible individuals more than the amounts generally billed (AGB) for emergency or other medically necessary care.

Self-pay patients will be provided information regarding the financial assistance policy at PSH. See **Financial Assistance Policies - PFS-051/PFS-053.**

- It is the expectation of PSH that all guarantors/patients will make every reasonable and good faith attempt to pay for the services provided by PSH.
- Additionally, it is the responsibility of the guarantor/patient to provide PSH with complete and accurate demographic information. Failure to do so may result in the use of extraordinary collection actions.

The guidelines for the expectations of the patient are outlined below.

Patient Financial Responsibility for Scheduled Health Care Services:

- If it is determined during scheduling or registration that the patient lacks health insurance or has limited benefits, accounts will be referred to a financial counselor.
    - Financial Navigators will provide price estimates to all patients upon request.
    - If a patient indicates he/she cannot pay the patient responsibility estimate, financial counselors can pre-screen the patient/guarantor to determine if an individual is eligible for governmental programs or financial assistance.

- Individuals determined to be eligible for government programs or financial assistance will be given options on how to apply.
  - It is the individual's obligation to provide PSH with the required financial information requested on the application.
  - All patients requesting financial assistance from PSH will be required to provide all necessary information to establish their inability to pay.
- Services that are not medically necessary may be postponed or cancelled for patients who are uncooperative or are unable to assist PSH by providing necessary information to establish their ability to pay or need for financial assistance.
  - Medical necessity will be determined by the PSH provider and medical staff. Please refer to the definition of Medically Necessary under the Definitions section of this document.
    - Financial counselors will contact the providers and ask them to provide additional information relative to the patient's medical condition and need for immediate attention. Only services deemed not medically necessary will be postponed or cancelled as determined by the PSH medical staff, see the Financial Risk Procedure**.**
  - PSH will continue to provide medically necessary services while financial counselors proactively work with the patient to satisfy financial obligations.
- If an individual does not meet the qualifications for governmental programs or financial assistance, the option of monthly payment plan is available.
- Failure to provide the necessary information or establish a month payment plan could result in the individual's account being forwarded to an outside collection agency for further collection on balances.
- Patients with foreign addresses - It is the policy of Penn State Health to collect outstanding balances at the time of service for all patients with foreign insurances seen at a non-acute facility, associates managing patients at acute facilities are expected to gather all pertinent information to be able to bill the patient for all services rendered.

Following the provision of services, guarantor balances and self-pay balances will be billed to the guarantor. The following are the guidelines for this billing statement process.

Billing Statements

- A statement of hospital and/or physician services is sent to the patient/guarantor in a minimum of four incremental thirty day billing cycles.
- All patients/guarantors may request an itemized statement for their accounts at any time.
- If a patient disputes his or her account and requests documentation regarding the bill, staff will respond to the patient/guarantor in a timely fashion and will hold the account for at least 30 days before referring the account for collection.
- Revenue Cycle representatives or contracted vendors may attempt to contact the patient/guarantor (via telephone, mail, collection letter, or email) during the statement billing cycle in order to pursue collections or pursue financial assistance opportunity. Collection efforts are documented on the patient's account in the billing system. Every reasonable attempt will be made to contact the guarantor/patient regarding his/her outstanding balance.

- The final billing statement message indicates that the account may be referred to an outside collection agency if it is not paid within 30 days from the date of the letter.
- Patients or guarantors who are actively engaged with PSH Patient Financial Services/vendors, as determined by PSH, regarding financial assistance will not have their accounts sent to a collection agency.
- Patients/Guarantors will continue to receive billing statements while actively engaged with PSH Patient Financial Services/vendors and the financial assistance application process.
- PSH complies with 501(r) billing and collection requirements.
- PSH complies with No Surprises Act's requirements.

It is the patient/guarantor's obligation to act in good faith and make reasonable efforts to pay for services provided at PSH. Patients who do not wish to apply for government assistance, do not qualify for financial assistance, or who are over the income requirements and need assistance paying for services may request a payment plan. The following are guidelines for establishing a payment plan.

Payment Plans

- PSH offers a payment plan arrangement if a patient/guarantor is unable to pay his/her bill in full and is not eligible for financial assistance.
- The payment plan is based on the outstanding amount due and is requested to be resolved within a reasonable amount of time as determined by PSH leadership (6-24 months), see Payment Plan Guidelines.
- Individuals who have not entered into a formal payment plan with PSH could be subject to an outside collection agency for further collection.
- Individuals are expected to make payments on time each month.
- An account becomes delinquent when the patient/guarantor does not pay the agreed monthly payment within 30 days of the statement date. Delinquent accounts could be subject to an outside collection agency for further collection.

If a patient/guarantor anticipates missing a payment or household income has changed, the individual can apply for financial assistance; see **Financial Assistance Policies - PFS-051/PFS-053.**

- PSH may pursue further collection on balances in the absence of reasonable efforts by the patient or guarantor to pay for an outstanding bill. This includes but is not limited to, not providing the necessary information to complete the financial assistance process or a payment plan as described above. The following are guidelines for the extraordinary collection actions process.

Extraordinary Collection Actions

- **External Collection Agencies** – PSH Revenue Cycle Department's responsibility is not to assign accounts for external collection nor engage in extraordinary collection actions before making reasonable efforts to determine whether the patient is eligible for Financial Assistance.
  - 120/240 day rule – A 120 day period during which a hospital facility is required to notify an individual about FAP and a 240 day period during which a hospital facility is required to process an application submitted by the individual. PSH will

provide notices during a notification period ending a minimum of 120 days after the date of the first billing statement. Hospital facility may not initiate ECAs (extraordinary collection actions) against an individual whose FAP eligibility has not been determined before 120 days after the first post discharge statement.
    - Accounts will be adjusted when turned over to the collection agency.
    - PSH will suspend any ECAs against a patient once the patient has submitted a FAP Application, regardless if the application is complete or not.
    - Accounts without an established payment agreement with the patient/debtor will be returned to PSH by the agency after no longer than 730 days (two years) from placement with said agency.
    - PSH complies with 501(r) billing and collection requirements.
- **Credit Reporting** - The outside collection agencies may report accounts to external credit reporting agencies. PSH and the outside collection agencies will comply with the Fair Debt Collection Practices Act and Federal Trade Commission Telephone Consumer Protection Act, and 501(r) regulations throughout all collection activities.
- **Bad Guarantor Address (BGA)** – PSH will make reasonable efforts to respond to all patient statements returned by the United States Post Office (USPS) that are not deliverable. Accounts whose most recent demographic information contains a BGA designation may be referred to an outside agency as bad debt for additional follow up for a minimum of 120 days prior to placement, however these accounts will not be subject to an extraordinary collection action event until the requirements of notification are satisfied. It is the intent of this policy to be in compliance with 501(r) regulations.
- **Attorney Placement** – In certain cases based on the outstanding balance threshold and ability to pay, and/or pattern of non-payment by the guarantor or third party payer, PSH may pursue legal action to collect patient balances.
    - Accounts identified for legal action should be identified separately from bad debt accounts turned over to a collection agency.
    - PSH will send a written notice to all patients recommended for legal action.
    - All accounts recommended for legal process will be reviewed and evaluated within 30 days. During the assessment period, the account will remain in active A/R status. Once it is approved for the legal agency, the account will be classified as bad debt.
    - If a judgement/lien court notice has been received, the appropriate adjustment will be made on the accounts as identified in the notice, the account will be documented, and the notice filed.
    - PSH will suspend any ECAs against a patient once the patient has submitted a FAP Application, regardless if the application is complete or not.
    - PSH complies with 501(r) billing and collection requirements.

- **Termination of Physician/Patient Relationship** – PSH may terminate a patient/physician relationship if the patient is delinquent in paying for care. **Patients will not be dismissed for medically necessary or urgent care.** The Medical Director, Manager and Physician must all agree to terminate patient care and agree on the level of termination.
    - Delinquent in paying for care includes, but is not limited to:
        - Non-payment or substantial underpayment of bills, despite the capacity to provide payment. Efforts should be made to assist patients in securing financial assistance or when possible establishing reasonable payment plans, see **Financial Assistance Policies - PFS-051/PFS-053**

        - Refusal to cooperate with Revenue Cycle staff to enroll in applicable third party payer programs in securing assistance.
- **Medicare Cost Report Reimbursable Bad Debt** – Guidelines and regulations set forth under the CMS Regulatory Requirements regarding Medicare bad debt will be followed.

RELATED POLICIES AND REFERENCES

It is the intent of PSH that this policy is within the guidelines and regulations set forth in the No Surprises Act, Federal Register under Section 501(r) and under the CMS Regulatory Requirements regarding Medicare bad debt.

Financial Assistance Policies - PFS-051/PFS-053

Patient Dismissal Policy (135-MGM)
Financial Risk Procedure

Payment Plan Guidelines

APPROVALS

Authorized:	Paula Tinch, Senior Vice President and Chief Financial Officer
Approved:	Dan Angel, Vice President, Revenue Cycle

DATE OF ORIGIN AND REVIEWS

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Revised: 01/05/2008, 6/10/11, and 07/01/2016 (Replaces: Patient Responsibility Collection Process, 10/06); 4/15/21, 11/2021, 10/2022

2017 Transitioned to Penn State Health combined policy – The following St. Joseph policies were incorporated into the Penn State Health Policy:
- ADM-CRP-64 – Patient Credit and Collections
    - 1-10 - Collections
    - Stewardship #16 - Collections
- 1-3 – Patient Collections Bad Debt
- 1-4 Bad Debt/Self-Pay Settlement
- 2-8 Legal Accounts Referral
- 3-2 Judgement/Liens
- St. Joseph professional - Bad Debt policy
- St. Joseph professional – Managing Patients with Foreign Addresses
- St. Joseph professional – Financial Agreement for Surgeries and Procedures
- CPMG – Self-pay Collections

CONTENT REVIEWERS AND CONTRIBUTORS

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