

# The Medical Account Resolution Process

**Goal:**

We believe that most patients want to resolve their accounts in a responsible manner. However one of the challenges facing them is the highly variable processes healthcare providers use to resolve accounts which contributes to confusion. Therefore, our goal is to identify a common set of account resolution practices that align with HFMA's Patient Friendly Billing Principles and simplify the process for patients. These should be standardized for widespread industry adoption leading to improvement in the overall collection process, patient experience, and financial performance, while ensuring a fair collection process for patients. A key component of this is educating the patient about the account resolution process, which ideally begins prior to patient registration.

- Patient's Account Is Screened for<sup>1,3,7</sup>:
- Primary/Secondary Payer for Billing
  - Accurate Payment Made/Posted from Primary Payer
  - Discounts for Necessary Care Provided to the Uninsured
  - Eligibility for Public Programs
  - Charity Care is Granted Based on Provider's Financial Assistance Policy Is Applied

**Post-Service Account Resolution: Part I**  
Account Resolution Efforts Continued From Pre-Service/Time of Service

A Clean Bill Is Sent to Patient for Their Portion of the Financial Responsibility for Services Rendered<sup>1, 2, 15, 16</sup>

Patient Pays

Patient Does Not Pay<sup>1</sup>

Small Balance Resolution Options:

- Resolve the Account Internally (see)
- Provider Acct Resolution Efforts)
- Send to early out business associates
- Administrative Write off of account

- (includes "Early Out")<sup>3, 4, 5, 6, 7, 8, 10, 12</sup>
- Insurance Verification/COBRA Eligibility
  - Eligibility for Public Programs
  - Eligibility for Financial Assistance
  - Bankruptcy Screen
  - Data Scoring
  - Presumptive Score Review
  - Calls/Letters
  - Installments<sup>1,3,7</sup>
  - Third Party Loans
- Patient Pays

Patient Does Not Pay<sup>1</sup>

**Post-Service Account Resolution: Part II**  
Bad Debt Account Resolution Process

Transfer Account to Collection Agency<sup>1,3,4,6, 9, 10,11,15</sup>

Patient Pays<sup>12</sup>

- Collection Agency Efforts<sup>9, 10</sup>  
Depending on Provider Board Approved Policy Options May Include:
- Screening or Scrubbing :
- Insurance, Charity Care Eligibility, Bankruptcy
  - Deceased
  - Data Integrity, Propensity to Pay
  - Asset Verification

Patient Does Not Pay<sup>1</sup>

Closed and Returned to Provider<sup>3</sup>

- Provider Options**
- Second Placement with Collections<sup>1,3,4,6,7,9,13,14</sup>
  - Debt May be Sold by Provider<sup>1, 3, 4, 6, 7, 9, 13, 14, 17</sup>
  - Stop All Collection Activities

Patient Pays<sup>12</sup>

IF REPORTED:  
Remove Credit Bureau Report<sup>7</sup>

- Continued Efforts to Resolve Account<sup>1, 2, 3,9, 10</sup>  
Optional Extraordinary Collection Activity:  
● Report to Credit Bureau<sup>6,7,13,14</sup>  
Legal Actions as Necessary:  
● Wage Garnishment  
● Liens

As recommended by the Medical Debt Advisory Task Force, the following suggestions are intended to provide guidelines to support fair debt collection policies and procedures.

## Explanation of Guidelines

- 1) Provider should make reasonable effort to ensure accurate and complete patient financial responsibility by taking the following steps:
  - Ensuring correct balance after any insurance by verifying proper payment amount from insurance and provider application of contractual allowances prior to final patient billing
  - Attempting to enroll true self pay patients in any applicable public program(s), COBRA, or other Insurance Programs as suggested in HFMA's *Patient Friendly Billing Report Hospitals Share Insights to Improve Financial Policies for the Uninsured and Underinsured Patient*
  - Screening for financial assistance/charity care (may include use of presumptive eligibility)
  - All processes outlined in this document must adhere to HFMA's Patient Friendly Billing Principles.
    - a. Provider should take responsibility for engaging patients in a constructive manner to help them understanding the billing process and patient's responsibilities within it as suggested in HFMA's Patient Friendly Billing Report Consumerism in Healthcare: Achieve a Consumer-Oriented Revenue Cycle.
      - i. Patient education should begin at scheduling for elective services and as soon as possible for emergent services once Emergency Medical Treatment and Active Labor Act (EMTALA) has been satisfied. Patient education should occur at each touchpoint possible (e.g. pre-registration, registration, discharge, account resolution events). Education should include discussion of available financial assistance, public assistance programs, and available payment options, as well what to expect during the account resolution process. Conversations prior to service should include an estimate of the patient's responsibility for services where possible.
      - ii. Patient education should reinforced throughout the account resolution process.
    - b. All parties involved (provider, patient, and payer) share responsibility to resolve any issues related to the patient bill.
- 2) Collection process clock starts at first statement date from provider's system.
- 3) Transfer of accounts between provider and business associates can occur at any time in the debt resolution process.
- 4) All business associates need access to relevant data to service accounts. This includes but is not limited to the date of first statement and all subsequent statements.
- 5) Early out collections should be an extension of the business office, accountable to provider's policies and procedures related to self-pay accounts.
- 6) Reporting an account to a credit bureau should occur no earlier than 120 days from first provider (or early out agency acting on behalf of a provider) statement.
- 7) If a provider/business associate elects to report an outstanding debt to a credit bureau and the debt is subsequently satisfied (includes accepting a settlement for less than full value as paid in full), the report should be deleted. Providers/agencies that choose not to report are exempt from this step.
- 8) Offer payment plans that consider the economic circumstances of the community.
- 9) Policies related to extraordinary collections activity (ECAs) (as defined by the IRS - i.e. liens, credit reporting, lawsuits, wage garnishments, or sale of debt) are board approved, and communicated to and practiced by collection agencies. Ongoing provider efforts to educate patients about the account resolution process should include informing patients of the ECAs that are board sanctioned.
- 10) All business associates involved in account resolution activities are required to report patient complaints.
  - a. Review by management teams to change practices to avoid future complaints.
    - i. (i.e.) billing/registration and other RC issues that result in inappropriate accounts sent to collections
    - ii. Call audits and other quality assurance activities to ensure that policies are followed and provide process improvement
- 11) If account is delinquent, communicate to the patient the potential exists for all board approved extraordinary collection activities (including reporting to credit bureaus) prior to initial placement. Accounts in early out should not be considered delinquent.
- 12) Regular reconciliations should occur between provider system and business associate system to insure balances are in sync (i.e. take backs) for accounts in bad debt. Providers should also ensure through the reconciliation process that only one business associate is working on an account.
- 13) Reconciliation should occur between business associate and bureau for account update. Remove a paid debt or account that is challenged in accordance with ACA International Guidelines.
  - a. Timeframe of 45 days
  - b. Need acknowledgement of data transmission – a reconciliation – that verifies receipt of information and completion of task.
  - c. Need to define the dataset between bureau and provider/business associate
- 14) Credit Bureaus should provide a reconciliation of consumers reported to the bureau vs. consumer files marked
- 15) All collection efforts (either internal or external) should adhere to internal written/formal provider collection policies, which include but are not limited to screening individuals for and applying charity care/financial assistance policies to those who are eligible and permissible account resolution tactics.
- 16) All provider organizations should have a charity care policy that is easily accessible to patients.
- 17) If debt is sold, the buyer must be certified by DBA International.

### Presumptive Eligibility Criteria:

Establish an objective and unbiased presumptive scoring for charity care (either full or partial discount) for both full balances or balances after insurance. These models should comply with IRS regulatory pronouncements when they become available. Until then, they should adhere to HFMA Principles and Practices guidelines which are available at: <http://www.hfma.org/FinancialAssistancePolicy/>

- Use a presumptive eligibility model that relies on multiple data sources and providers believe has a high degree of predictive accuracy
- Use providers charity care/financial assistance policy
- Use income/family size calculations
- Use as a screening tool during registration, financial counseling, and back end collections