



Patient Collections Fact Sheet

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This document contains advice on the following topics:

- Financial hardship*
- Discounts*
- Bad checks*
- Collection letters*
- Collection calls*
- Filing 1099s*
- “Paid in Full”*
- Summary of websites*
- Sample credit worthiness policy*

This document is not meant to provide legal advice and should not be considered a substitute of such expertise.

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Information on Financial Hardship and Discounts

Interest Charges and Finance Charges

Although harsh or commercial collection practices are discouraged in the practice of medicine, a physician who has experienced problems with delinquent accounts may properly choose to request that payment be made at the time of treatment or add interest or other reasonable charges to delinquent accounts. The patient must be notified in advance of the interest or other reasonable finance or service charges by such means as the posting of a notice in the physician's waiting room, the distribution of leaflets describing the office billing practices, and appropriate notations on the billing statement. The physician must comply with state and federal laws and regulations applicable to the imposition of such charges. Physicians are encouraged to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge. Physicians who choose to add an interest or finance charge to accounts not paid within a reasonable time are encouraged to use compassion and discretion in hardship cases. (II) Issued prior to April 1977; Updated June 1994.

Source: American Medical Association.

See www.ama-assn.org

Discounts to Uninsured Patients and Underinsured MCR/MCD Patients

On February 2, 2004, the OIG announced a clarification to their discount policy:

"No OIG authority prohibits or restricts hospitals from offering discounts to uninsured patients who are unable to pay their hospital bills. No OIG authority rule or regulation requires a hospital to engage in any particular collection practices. Providers may forgive a Medicare coinsurance or deductible amount in consideration of a particular patient's financial hardship."

In response to a letter from the Healthcare and Billing Management Association (HBMA) regarding the applicability to physicians, the OIG clarified:

"From the OIG's perspective, the same principles and analytical framework that we set forth in our February 2004 guidance regarding hospitals, "Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills," apply equally in all health care contexts, including discounts offered by physicians and other health care practitioners." OIG, June 8, 2004

Sample Charity Care Policy

Patients are expected to pay for services rendered. The practice will assist patients who indicate they are unable to meet their financial obligations resulting from care provided by our practice. Patients may be determined as eligible for partial to full discounts utilizing the current poverty guidelines issued by the state.

Procedures:

1. Exclusions from this policy are:
 - a. Medical care defined as not medically necessary (cosmetic surgery, etc)

- b. Services rendered to persons who are eligible, but have not applied for, medical insurance or assistance programs sponsored by Federal, State, or local government.
- 2. Financial Hardship/Charity Care may be extended to those who qualify for all four (4) of these reasons:
 - a. The patient is not eligible for Medicaid or pending Medicaid approval;
 - b. The patient is determined to be unable to pay for services provided;
 - c. The patient is unable to accept an installment payment arrangement; and
 - d. The patient agrees to make payment at the time the discount is granted.

For patients who identify themselves or are identified by Practice staff to be considered for financial hardship/charity care, staff will obtain financial information from the patient. Presumptive eligibility can be based on their current status with State agencies (e.g., Food Stamp Program, WIC, etc). If not applicable, patients will be requested to submit a copy of their last two pay checks stubs; current year Federal 1040 tax return; and, if applicable, unemployment benefits check stubs. The Practice will assist patients as much as possible to compile their information.

- 3. The billing staff will determine eligibility for financial hardship or charity care. Discounts on charges will be calculated as follows:

Percent of State/Federal Poverty Level	Discount
300%	30%
200%	50%
100%	75%
<100	100%

An adjustment code will be assigned to each level of discount.

- 4. The granting of the discount will be noted in the patient’s account. The patient’s account status, however, will never be permanently designated as charity care or financial hardship. The patient’s status will be reviewed on a regular schedule.

Prompt Pay Discounts

OIG Advisory Opinion No. 08-03

NOTE: This is an “Advisory Opinion” only; “This advisory opinion is limited in scope to the specific arrangement described in this letter and has no applicability to other arrangements, even those which appear similar in nature or scope.”

“The Health System would not advertise the discount opportunity. Patients and their representatives would only be informed of the Prompt Pay Discount’s availability during the course of the actual billing process. The Health System has certified that other third-party payers would be notified of the prompt payment policies. In addition, the Health System has certified that all the costs of the arrangement would be borne by the Health System. Finally, the Health System has certified that the amount of fees discounted to patients under the Proposed Arrangement would bear a reasonable relationship to the amount of avoided collection costs. We believe that these features reduce the likelihood that the Proposed Arrangement would be used as a means to draw additional

patient referrals to the Health System and is consistent with the characterization of the Proposed Arrangement as a prompt payment discount implemented for the purpose of more successful bill collection.”

“The Prompt Pay Discount would be offered in connection with both inpatient and outpatient services and would be offered to insured patients regardless of their financial status or their ability to pay. Patients would benefit from the Prompt Pay Discount in the following two circumstances: 1) when payments are made on a hospital bill prior to the discharge of the patient; or, 2) when payments are made after discharge, but within thirty (30) days of the patient’s being informed of the discount offer. The size of the Prompt Pay Discount would depend on both the timing of the payment and the size of the remaining balance owed by the patient. The Prompt Pay Discount would be awarded according to the following schedule:

% of Bill Discounted on Payments Made Prior to Discharge

Balances \$0 -- \$999 = 10%

Balances ≥ \$1,000 = 15%

% of Bill Discounted on Payments Made Post-Discharge But Within 30 days of Discount Offer

Balances \$0 -- \$999 = 5%

Balances ≥ \$1,000 = 10%”

Advisory Opinion published February 8, 2008 by the Office of the Inspector General;
Source: <http://oig.hhs.gov/fraud/docs/advisoryopinions/2008/AdvOpn08-03A.pdf>
See also: http://www.foley.com/publications/pub_detail.aspx?pubid=4774

Waiver of Copayments and Coinsurance (see also Professional Courtesy)

Regarding financial hardship for patients who are insured, but cannot afford to pay their portion of the balance, the American Medical Association recommends: “Under the terms of many health insurance policies or programs, patients are made more conscious of the cost of their medical care through copayments. By imposing copayments for office visits and other medical services, insurers hope to discourage unnecessary health care. In some cases, financial hardship may deter patients from seeking necessary care if they would be responsible for a copayment for the care. Physicians commonly forgive or waive copayments to facilitate patient access to needed medical care. When a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment. A number of clinics have advertised their willingness to provide detailed medical evaluations and accept the insurer's payment but waive the copayment for all patients. Cases have been reported in which some of these clinics have conducted excessive and unnecessary medical testing while certifying to insurers that the testing is medically necessary. Such fraudulent activity exacerbates the high cost of health care, is unethical, and violates Current Opinion 2.19. (Physicians should not provide, prescribe, or seek compensation for services that they know are

unnecessary.) Physicians should be aware that forgiveness or waiver of copayments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of copayments may constitute fraud under state and federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers.

Source: Ethical Opinion 6.12 - Forgiveness or waiver of insurance copayments, 1993
<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion612.shtml>

Further, the Office of the Inspector General advises, "One important exception to the prohibition against waiving copayments and deductibles is that providers, practitioners or suppliers may forgive the copayment in consideration of a particular patient's financial hardship. This hardship exception, however, must not be used routinely; it should be used occasionally to address the special financial needs of a particular patient. Except in such special cases, a good faith effort to collect deductibles and copayments must be made." Source: Office of the Inspector General Special Fraud Alert, December 19, 1994.

See also OIG February 2004 Letter

See: www.hhs.gov/oig

Remuneration for service failures

A health system requested guidance from the Office of the Inspector General regarding the use of gift cards for service failures. The cards are \$10 in value, with a limit of \$50 per annum, redeemable at certain local vendors, excluding the health system. The program would not be advertised. Historically, the OIG has considered any remuneration to patient as an inducement for referrals. On July 28, 2008, the OIG issued a statement in favor of the gift cards: "we conclude that (i) the Proposed Arrangement would not constitute prohibited remuneration within the meaning of section 1128A(a)(5) of the Act; and (ii) while the Proposed Arrangement could potentially generate prohibited remuneration under the anti-kickback statute, if the requisite intent to induce or reward referrals of Federal health care program business were present, the OIG would not impose administrative sanctions..."

Source: OIG Advisory Opinion No. 08-07

<http://oig.hhs.gov/fraud/docs/advisoryopinions/2008/advopn08-07.pdf>

Professional courtesy

Beginning July 26, 2004, professional courtesy is defined in Stark II as "the provision of free or discounted health-care items or services to a physician or his or her immediate family members or office staff." In addition to the prohibition to Medicare patients, professional courtesy rules include:

- Must be offered to all physicians on the practice's staff or in the local community without regard to volume or value of referrals;
- May include only those services regularly offered by the practice;
- Must be a policy written and approved by top practice management;
- Cannot be offered for copay waivers unless the insurance company paying the bill is informed in writing; and
- Does not violate anti-kickback laws or claims submission rules and regulations.

See the March 26, 2004, *Federal Register* at <http://www.cms.hhs.gov/PhysicianSelfReferral/Downloads/69FR16054.pdf>

The American Medical Association issued its policy statement regarding professional courtesy in June 1994; reaffirmed in February 2008: "Professional courtesy refers to the provision of medical care to physician colleagues or their families free of charge or at a reduced rate. While professional courtesy is a long-standing tradition in the medical profession, it is not an ethical requirement. Physicians should use their own judgment in deciding whether to waive or reduce their fees when treating fellow physicians or their families. Physicians should be aware that accepting insurance payments while waiving patient co-payments may violate Opinion 6.12. (II, IV)".

<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion613.shtml>

Advice on Handling Bad Checks

If you're struggling to handle bounced checks – also called NSF or non-sufficient funds checks -- in your billing office, it's time to look at your personal check acceptance process. Experts in the check recovery business report that 70 percent of bad checks are unintentional, and 30 percent are the result of fraud.

Many patients provide personal checks at the time of service. While the patient is in front of you, instruct your staff to perform the following steps:

- * Make sure the check is complete and correct, including the practice's name, the dollar amount, and the signature. This may seem like a no-brainer, but this is an easy tactic for a patient who doesn't want to pay and sees a receptionist who is busy with other tasks.
- * Examine the check closely. If it looks suspicious, it probably is. Patients have been known to print documents looking like checks from desktop publishing at home. The check should be perforated on one side (usually, but not always, the top). Other red flags are low check numbers, or checks that are out-of-state, third-party, post-dated, Social Security, business, or payroll.
- * Ask for photo identification (ID). Copy or scan the image (back and front) and file it with the patient's record. Check to make sure that the ID -- picture, physical description, and signature -- matches the person signing the check. Record a phone number, driver's license number, and address on the check. Before you establish the process, however, make yourself aware of your state law regarding what you can -- and can't -- ask for and record in terms of an ID and personal information on the check.

You also need to have these general office policies in place:

- * Promptly cash checks sent via mail. Patients often pay their statements by personal check, so it's important for you to identify bad checks early. This means daily deposits to the bank or the use of a lockbox, with timely communication from your bank regarding any problems. Try contacting the patient who wrote a bad check immediately, and flag the account for collections if you have no response. The rule of thumb is that every 30 days that goes by diminishes the value of the account by 10 percent.
- * Use a check-verification or guarantee service. Vendors such as TeleCheck (www.telecheck.com) offer assistance with personal checks. The vendor performs an electronic verification of the patient's account to determine whether the personal check is good or bad. If the check is a problem, hand it back and ask for alternative payment. While verification won't guarantee payment, it certainly increases your chance of recovery – and it's cost-effective. These vendors also offer guarantee services which essentially turns a personal check into a debit card, thus transferring the funds from the

patient's bank account to yours at the time of the processing, although these services are more expensive. Check with vendors to determine pricing and service.

* Seek government assistance. Some governments provide assistance with check recoveries; check with your local district attorney's office regarding restitution. Furthermore, small claims court can provide an opportunity to take the patient to pursue payment through the legal system, although rules vary by state.

* Flag accounts. Identify bad check writers - intentional or not - in your billing system with an alert note. Ask for alternative payment from the patient in the future.

Consider eliminating personal checks altogether. Since most Americans now use credit and debit cards, many businesses have simply stopped accepting personal checks. Because customers have alternatives, there is little to no negative implications for that decision. Discontinuing the acceptance of personal checks allows you to avoid the problems with bad checks without a lot of downside. If you do stop accepting personal checks, make sure you inform your patients in advance of implementing the policy. Use your registration process to inform patients about your new policy, and include notification of the new policy in your statements. Offer easy alternatives to your patients, to include accepting credit cards on the statement.

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Advice about Collection Letters

- Keep the letter to less than 50 words
- Be simple and to the point
- Be positive (“Your cooperation”) v. negative (“You are delinquent”)
- Give options (“Call for payment”, “Call to establish payment plan”, or ...)
- Close with a compelling request and a specific timeline (“The payment due from you is \$xx. If we don’t hear from you by Friday, your account will be sent to collections...”)
- Mail

Find examples at:

www.collect.org/Help/reports/index.html#debtorsamples

In your letters (and actions), the FDPCA states:

- Do not deceive
- Do not threaten what you aren’t intending to do (i.e., don’t threaten to send to a collection agency when you’re not really planning to)
- Do not misrepresent yourself, such as writing a letter calling yourself a “Collection Agency” or “Credit Department”

Advice about Collection Calls

Be in charge of the call at all times. Respect the family/guarantor/patient. Do not intimidate. Come across as helping them, as working together to solve this problem.

“My name is Mary Jones from Dr. Smith’s office [NOTE: use the doctor’s name, not the practice], and I’m calling about the bill that you received from him. I am concerned that it is past due, and wanted to speak with you about the bill.”

WAIT. LISTEN.

No matter how long or how uncomfortable the silence is, let the patient break it.

If they haven’t told you the reason for non-payment, ask. *“Mr. Walker, help me to understand why you are unable to pay this bill.”*

WAIT. LISTEN.

If the patient indicates that he/she intends to pay, get a credit card number right away. Send a receipt with a ‘thank you’ note.

Is it a financial reason (need some more time)? Offer options. Work out a payment plan.

Is it a financial hardship? Explain your charity care policy.

Use discounts/waive interest when possible.

If it’s a ‘deadbeat’ guarantor (30%+ are), transfer to a collection agency immediately.

If answering machine: *“I am calling from Dr. Smith’s office. It is very important that you call me back. My name is Mary Jones, and my number is 800-666-5122.”*

Advice about Filing IRS 1099s

- Used by some practices to report patient income to the IRS.
- Often used by practices when a patient receives payment from an insurance company directly and refuses to pay their bill.
- Demonstrates a cancellation of debt, which means that you may not pursue the patient for payment ever again.
- Author ***cautions against using these forms*** for the following reasons:
 - For the 1099Cs, Instructions do not include medical practices as having the ability to file the form (see below). www.irs.gov/instructions/i1099ac/ar02.html#d0e334F
 - For the 1099-Miscellaneous, Instructions state: “File...for each person to whom you have paid...at least \$600...” Instructions do not include use for debt. www.irs.gov/pub/irs-pdf/i1099msc.pdf
- Remember, if you threaten to report a patient to the IRS, you must follow through to comply with the Fair Debt Practices Collection Act which prohibits making threats with no intended actions. Because there is no form to use, simply write a letter to the IRS informing them of the debt.
- Please check with your accountant before you file.

[From the instructions] File Form 1099-C if you are:

A financial institution described in section 581 or 591(a) (such as a domestic bank, trust company, building and loan or savings and loan association). A credit union.

- A federal government agency including:
 - A department,
 - An agency,
 - A court or court administrative office, or
 - An instrumentality in the executive, judicial, or legislative branch of the government, including government corporations.

Any of the following, its successor, or subunit of one of the following:

- Federal Deposit Insurance Corporation,
- Resolution Trust Corporation,
- National Credit Union Administration,
- Any military department,
- U.S. Postal Service, or
- Postal Rate Commission.

A corporation that is a subsidiary of a financial institution or credit union, but only if, because of your affiliation, you are subject to supervision and examination by a federal or state regulatory agency. ...Organizations whose principal trade or business is the sale of non-financial goods or non-financial services, and who extend credit to customers in connection with the purchase of those non-financial goods and non-financial services, are not considered to have a significant trade or business of lending money, with respect to the credit extended in connection with the purchase of those goods or services, for reporting discharge of indebtedness on Form 1099-C.

Advice about “Paid in Full” when Account Isn’t Paid in Full

- Patients will write, ‘Paid in Full’ on their checks in an attempt to close the account
- Problem with a lockbox (i.e., your practice never sees the checks), but discuss options with the bank serving as your lockbox
- If you have a “Paid in Full”, endorse with a statement that depositing the check does not represent accepting the payment as cancellation of the debt, dispute within 90 days or establish a “debt dispute office”.

For more information, see:

<http://consumer-law.lawyers.com/Paid-in-Full-Check-Memo.html>

Websites (links active as of February 2012)

Brochures about Medicare coverage and benefits: www.medicare.gov

Patient appeal support: www.patientadvocate.org

Statement templates: <http://www.hfma.org/Publications/E-Bulletins/Patient-Friendly-Billing/Archives/2010/September/From-Documentation-to-Conversation/>

On-line bill payment: Financial institution or vendor, e.g., www.checkfree.com, www.paymentonline.com, www.charge.com

Bad addresses: www accurint.com, www merlindata.com, www switchboard.com, www whitepages.com, www 411.com

Patient financier: www carecredit.com, www enhancepatientfinance.com, www capitalonehealthcarefinance.com

Credit bureaus: www Experian.com, www Transunion.com, www Equifax.com

Overview of small claims court process:
www.straightshooter.net/Get_Even_Legally.htm#HowtoSue

Truth in Lending law: http://en.wikipedia.org/wiki/Truth_in_Lending_Act

Fair Debt Collection Practices Act:
<http://www.ftc.gov/bcp/edu/pubs/consumer/credit/cre27.pdf>

Statement for your collection letters: "Unless this account or any portion thereof is disputed within 30 days from receipt of this notice, we will assume this debt to be valid. If you dispute this debt or any portion thereof within this 30-day time period, we will furnish at your written request, a verification of this debt. This is an attempt to collect a debt. Any information obtained will be used for that purpose."

Consumer-driven Health Plans: <http://www.treasury.gov/offices/public-affairs/hsa/pdf/HSA-Tri-fold-english-09.pdf>

Segmenting Patients based on Credit Worthiness
A New Collections Strategy

Probability of collections	 C	MCD/Charity Application (Elig for Discount?) 2 statements Agency	MCD/Charity Application (Elig for Discount?) 2 statements Agency	
	B	TOS All 2 statements Call (Live/Dialer) Early Out Letter Agency	TOS Deposit 2 statements Call (Live/Dialer) Early Out Letter Agency	
	 A	TOS All 2 statements Call++ (Live/Dialer) Early Out Series Agency	TOS Deposit 2 statements Call++(Live/Dialer) Early Out Series Agency	
		\$0 to \$100	\$100 to \$1,000	>\$1,000+

TOS Deposit = \$100 for new patients; \$50 for established
Probability:

A -- Insured, employed, historically paid

B -- Un- or insured, employed, historical paid partial/payment plan

C -- Uninsured, unemployed, historically no or partial payment

MCD = Medicaid

TOS = Time-of-service

Dialer = Predictive Dialer

Elig = Eligible

++ = several calls