| Policy Title | Credit and Collection Policy | Policy ID | 4834 |
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| Keywords | Credit, Collection, Bad, Debt | | |

## I. Purpose of Policy

To establish how Conifer Revenue Cycle Solutions ("Conifer") is to pursue and satisfy patient account balances as a contracted agent for Dartmouth Health (DH).

## II. Policy Scope

This policy applies to all staff responsible for the credit and collection processes and all balances billed through Dartmouth Health. This policy applies to those DH member facilities using the Epic system.

## III. Definitions

**Collection Agency:** A third party who collects balances that are considered in default.

**Debtor**: One who owes a debt.

**Dun Level**: The level of communication to a patient in relation to the patient's account(s) receivable. The higher the dun level, the closer the balance is to being considered in default.

**Default**: A balance that has not been paid according to payment terms identified on the statement, has no payment arrangement established, and is moved from active receivable to a collection agency.

**Guarantor**: Any patient over 18 years of age is identified as the guarantor (unless otherwise specified by the State or court), regardless of under whom the patient may be insured. For any patient under 18 years of age, the parent or legal guardian will be listed as the guarantor.

**ECA**: Extraordinary Collection Action

**Dartmouth Health:** For purposes of this policy Dartmouth Health System Members (DH) are Alice Peck Day Memorial Hospital, Cheshire Medical Center, Dartmouth Hitchcock Clinic, Mt. Ascutney Hospital and Health Center, New London Hospital, Mary Hitchcock Memorial Hospital, Hampstead Hospital, Southern Vermont Medical Center (SVMC), Valley Regional, and Visiting Nurse and Hospice for Vermont and New Hampshire (VNH). All other hospitals in New Hampshire and Vermont are considered Non-Member facilities.

This policy applies to those DH member facilities using the Epic system.

## IV. Policy Statement

- DH routinely attempts to collect the most current Guarantor insurance information for a patient and verify coverage and out-of-pocket responsibility through existing insurance and benefit verification tools.
- Out-of-pocket expenses such as co-insurance and deductible balances are estimated for payment arrangements sought prior to service or at the time of service.
    - A patient may have the option of paying out-of-pocket expenses after services are rendered.
    - Some services may require prepayment (e.g., cosmetic, hearing aids, etc.).
- For any unpaid balances, DH will issue the billing statement and request payment in full.
- Partial payments are accepted as long as minimum payment expectations are met as outlined in the budget plan procedure. See "Budget Payment and Reinstatement Plan Procedures: Revenue Management Division" (linked below).
- Outstanding balances may move to collections when the balances are deemed uncollectible and at that time, the balances are moved to a collection agency, are considered in default, or outstanding balances may be classified as bad debt.

### A. Self-Pay Balances

- Self-pay balances represent charges that are the responsibility of the Guarantor.
- These include but are not limited to:
    - Balances on accounts for individuals without insurance.
    - Balances after insurance or third-party payments including:
        - Charges considered as non-covered services as defined by the patient's insurance plan
        - Co-payments
        - Co-insurance
        - Deductible amounts
    - Guarantors who bill their own insurance and elect to not make assignment to DH
    - Patient convenience items

### B. Transfers to Self-Pay

- Balances move to the Guarantor and statements are sent only after payments for services have been settled with third-party payers, unless the following conditions are met:
    - DH has not been successful in having the claim adjudicated by the payer, despite repeated attempts to seek payment.
    - DH has been notified by the third-party insurer that the Guarantor has not responded to requests for information needed to adjudicate the claim.
    - The Guarantor provides incorrect insurance information. The first statement generated to the patient will provide the phone number of customer service and a request to update insurance information if not correct.

### C. Patient Billing Statements

- Guarantors currently receive statements as follows:
    - Resolute Hospital Billing
        - All hospital services and all hospital-based MD Office visits.
    - Resolute Professional Billing
        - Professional fees for providers (excluding hospital-based ambulatory services, including dental services).

- General guidance for the production of statements for hospital and clinic services are as follows:

  1. Statements are normally produced on a monthly basis.
  2. All statements are generated at the Guarantor level, meaning multiple visits or multiple invoices will be listed on a single statement.
  3. The next statement dates and dunning levels are assigned prior to producing the statement based on payments posted.
  4. To suspend dunning, a minimum payment must be made either related to an established budget plan.
  5. Guarantors who meet the minimum payment requirement on a timely basis will not have the dunning advance to the next level.

**D. Collection Agency Referrals**

- DH will not use extraordinary collection actions (ECAs) such as reporting to credit reporting agencies before making reasonable efforts to determine whether the patient is eligible for financial assistance. A patient will be sent to collections only after first making reasonable efforts to determine whether that patient is eligible for financial assistance (this includes the use of presumptive eligibility). Any exceptions must be approved by the Chief Financial Officer. For information on actions on financial assistance eligibility, please refer to our "Financial Assistance for Healthcare Services Policy" (see link below). Copies are available online or can be requested at the Patient Financial Services Offices or can be mailed to patients by calling 844-808-0730.
- DH will refrain from collection agency actions until at least 120 days after the first post-discharge billing statement is sent and DH will send a notice at least 30 days prior to sending to collections.

**E. Presumptive Charity**

DH may utilize a third-party to review the patient's information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socioeconomic and financial capacity score that includes estimates for income, resources, and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for the Dartmouth Health system.

Information from the predictive model may be used by DH to grant presumptive eligibility in cases where there is an absence of information provided directly by the patient. Presumptive financial assistance is not available for balances after Medicare.

Presumptive screening is used to provide financial assistance to patients who have not been responsive to the notification of the option to complete a Financial Assistance Application, without respect to outstanding balance, on eligible accounts greater than 120 days after statements, after notices to collect the debt and prior to referral of the account to an outside collection agency. Probate accounts that have exceeded time limits are eligible for presumptive screening.

Presumptive Charity does not replace traditional FAP processes; it is used to supplement these efforts, and meant for those patients who are otherwise unresponsive to the traditional FAP process. In an effort to remove barriers for these patients, and improve our benefit to the patient, the hospital uses an electronic screening process prior to bad debt placement. Patients found eligible for Presumptive Charity will not be placed with a bad debt collection agency.

Inclusion in this program is based on a scoring algorithm using public record information and does not typically use a sliding fee scale. Partial discounts are not allowed with Presumptive Charity. Specific demographic populations are intended to include:

- Deceased with no estate or known family
- Transient, homeless person
- Persons estranged from family with no support group
- Patients unresponsive or incapable of completing traditional process

Presumptive charity scoring incorporates a socio-economic factor and non-credit based data. The screening process leverages public databases that contain the following information:

- Consumer Transactions
- Court Records
- Asset Ownership
- Home ownership vs. renter
- Demographics, economics of the region
- Employment status
- Utility Files
- Governmental
- Files (Bankruptcy, SSN, deceased individuals)

Presumptive Charity does not rely on credit bureau reporting data and leaves no soft hits on credit reporting. The information obtained incorporates a Presumptive Charity score of 0 (most needy) to 1000 (least needy). The information predicts the need of the guarantor based on the known factors including but not limited to Income, Assets, and Liquidity.

**Identification of Eligible Accounts**

- A billing flag will be added to eligible accounts
- Medicare eligible will be excluded
- If approved, EPIC adjustment codes will be used to identify eligible accounts
  - 5027 Presumptive Free Care after insurance and code
  - 5026 Presumptive Free Care

## F. Vendor Credit Policy

- DH has the following three categories of client/vendor accounts:
  - Research study accounts
  - Commercial client accounts (e.g., Hospice, SNF, City Accounts, Lab, etc.).
  - Occupational Health accounts that have a contract for services required by an employer as a condition for employment will be paid by the employer.
- Monthly statements are produced and are due in full within 30 days of the statement date.
- No budget arrangements will be made on these accounts.
- Accounts over 30 days old are sent a letter indicating the amount past due and providing notice stating continued non-payment may result in interest charges at a rate of 1.5% per month on all outstanding balances.
- DH reserves the right to send accounts in default to Collection Agencies.

### G. Bankruptcy Accounts

- Two types of bankruptcy notices are sent by the Bankruptcy Court:
  - Notice of commencement of filing
  - Discharge/Disallowance of debtor
- Once DH has been notified of a bankruptcy, all collection attempts must cease.
- Notice of commencement is received by DH.
  - The filing can be either individual or joint and the children are not listed.
  - All family members must be identified and each account must be noted that bankruptcy proceedings have commenced and the date of filing.
  - If any account has been placed with an outside collection agency, the account must be noted, the agency notified, and a copy of the filing sent to the bankruptcy court for its records.
  - All charges specified in the notice will be included for purposes of bankruptcy.
  - All charges should be updated to the bankruptcy financial class.
- When the bankruptcy is finalized, the court will send either a disallowance or a discharge of debtor notice.

  In the case of a disallowance, DH can resume collections.
  - If DH receives a discharge we must adjust any balance in the Epic system.
  - All accounts pertaining to bankruptcy must be noted of the final outcome.
  - The collection agencies will be notified and sent any supporting documents.

### H. Litigation Claims

- DH will curtail the pursuit of self-pay balances or claim subjugation balances for accounts in litigation upon receipt of a Letter of Protection (LOP) sent by the attorney representing the patient stating the litigant will protect DH interest in any subsequent settlement.
- If the settlement is denied, the balances revert back to the guarantor and arrangements for payment are made.
- DH reserves the right to file a lien in liability cases for the interest of the hospital.

## V. References - N/A

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| **Responsible Owner:** | Revenue Management Division | **Contact(s):** | Kimberly Mender |
| **Approved By:** | Office of Policy Support (OPS); Mender, Kimberly; Muhlen, John | **Version #** | 13 |
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| **Related Polices & Procedures:** | Budget Payment and Reinstatement Plan Procedures: Revenue Management Division<br>Financial Assistance for Healthcare Services Policy | | |
| **Related Job Aids:** | | | |