

## 7. Collections

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## 7.1 Overview of Collections

IHS collection includes:

- Collection of monies for either the total amount of the procedure or service, or the remaining deductible and coinsurance amount for treating non-beneficiary patients
- Follow up with all insurance companies on any outstanding billed but not paid account
- Follow up with insurers on incorrectly paid claims (less than the contractually agreed upon amount)

All collection is important to the survivability of each facility. Regardless of the situation, IHS needs dedicated, trained staff either in

- Registration to collect and record monies received from non-beneficiaries, or
- Account Reconciliation to follow up with insurance companies in a timely manner.

If all processes are completed at the facility *except* for collections, the facility will not receive all of its intended reimbursement.

For more information on procedures for the collection and handling of monies received, see the *Indian Health Manual*, Part 5, Chapter 1, “Third Part Revenue Accounts Management and Internal Controls” (5-1.4), which is available at this website:

<http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part5/pt5chpt1/pageone.htm>

The following sections provide information on processes, procedures, and techniques for collecting from either the insurance company or from the patient directly.

## 7.2 Legal Aspects of Collection

### 7.2.1 Fair Debt Collection Practices Act of 1996

The Fair Debt Collection Practices Act is a Federal law which regulates the activities of those who regularly collect debts from others. The reason for the law is that there was abundant evidence of the use of abusive, deceptive, and unfair debt collection practices by many debt collectors that contributed to personal bankruptcies, marital instability, loss of jobs, and invasions of individual privacy. Many states have adopted similar laws regulating the practices of debt collectors.

While collectors employed by a facility are not covered by the Fair Debt Collection Practices Act, the following provisions of the Act will help avoid negative patient relations.

A debt collector

- May contact you by mail, in person, by telephone, or by telegram during “convenient hours” (commonly between 8AM and 9PM) and only once a day.
- May not call a debtor repeatedly or let the phone ring with the intent to annoy.
- May not contact you at work, if the collector knows or has reason to know that the employer forbids employees from being contacted by debt collectors at the workplace.
- May not contact a debtor, if the debtor is represented by a lawyer (the debt collector must then contact the debtor’s attorney).
- May not continue to contact a debtor after the debtor has sent the debt collector a letter by mail within thirty days of the first contact, stating that he/she disputes all or part of the debt (however, the debt collector may begin collection activities again if she/he sends the debtor proof of the debt).
- Must, within five days of the first contact, send the debtor a written notice stating the name of the creditor the debtor owes money to, the amount of money owed, what to do if the debtor believes he/she does not owe the money, and the name of the original creditor if different from the current creditor.

- May not threaten violence against the debtor or his/her property, use obscene or profane language, repeatedly telephone the debtor to annoy or harass him/her, make the debtor accept collect telephone calls or pay for telegrams, or use false or misleading information in an effort to collect the “debt.”

Additionally:

- Contacting a debtor on a Sunday or any other day that the debtor recognizes as a Sabbath, could be considered harassment.
- Repeated calls in one day could be considered harassment, even if a debtor has asked the collector to call back.

If a debt collector violates the law, it is the debtor’s right to write a letter concerning the activity to the nearest Federal Trade Commission, and to file a federal or state lawsuit against the debt collector for violation of the law, although there is usually a one-year “statute of limitation.”

## **7.2.2 Debt Collection Improvement Act of 1996**

The Debt Collection Improvement Act of 1996 (DCIA) fundamentally changed the manner in which the Federal government is required to manage the collection of its delinquent debts. The Act creates standards for administrative collection, compromise, suspension, and termination of Federal agency collections acts and is referred to as the proper agency for litigation.

Congress has directed that the management of delinquent obligations is to be centralized at the Treasury Department in order to increase the efficiency of our collection efforts. The Administration strongly supported this legislation and is fully committed to its successful implementation.

This act was designed for the following purposes:

- To maximize collections of delinquent debts owed to the Government by ensuring quick action to enforce recovery of debts and the use of all appropriate collection tools.
- To minimize the costs of debt collection by consolidating related functions and activities and utilizing interagency teams.
- To reduce losses arising from debt management activities by requiring proper screening of potential borrowers, aggressive monitoring of all accounts, and sharing of information within and among Federal agencies.

- To ensure that the public is fully informed of the Federal Government's debt collection policies and that debtors are cognizant of their financial obligations to repay amounts owed to the Federal Government.
- To ensure that debtors have all appropriate due process rights, including the ability to verify, challenge, and compromise claims; and access to administrative appeals procedures which are both reasonable and protect the interests of the United States.
- To rely on the experience and expertise of private sector professionals to provide debt collection services to Federal agencies.

It is required of all Federal agencies to aggressively service and collect delinquent debts, and to

- Report all delinquent debts to credit bureaus.
- Refer all eligible non-tax debts more than 180 days delinquent to the Department's Treasury Financial Management Services (FMS) for collection of FMS cross-servicing program.
- Adopt rules and procedures authorizing the use of all available debt collection tools, including offset and administrative wage garnishment.
- Ensure debtors are afforded due process as required by law, including the ability to seek verification and to dispute validity of the debt.

### **7.2.3 Fair Credit Reporting Act**

The Fair Credit Reporting Act is another law passed for consumer protection. This act affects those who "issue or use reports on consumers in connection with the approval of credit." It provides protection of consumers' rights to privacy and limits the use of credit reports.

Although health care patients are not usually refused credit based on a credit report, your office may be affected by the Fair Credit Reporting Act. If you refuse to grant credit based on a credit report, you must:

- Tell the patient why credit has been refused.
- Supply the name and address of the credit agency from which you got the credit report.

This gives the patient the opportunity to correct any errors or disputes on the credit report.

## 7.2.4 Fair Credit Billing Act

The Fair Credit Billing Act is another step in consumer protection and should be followed by health care providers. This Act states:

- Patients have 60 days from the date a statement is mailed to complain of an error.
- The creditor (facility) must acknowledge this complaint within 30 days of receiving it.
- The error must be corrected or the accuracy of the statement explained to the customer within two complete billing cycles or a maximum of 90 days.
- Creditors can be fined up to \$50 for each disputed transaction, if they do not follow these guidelines.

## 7.2.5 Third Party Collection Program

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) established the Third Party Collection Program. Under this program Military Treatment facilities and Indian Health Service facilities are authorized and obligated to bill health insurance carriers for the cost of medical care furnished to all family members who are covered by health insurance policies, such as group insurance, individual insurance, and Medicare supplemental policies.

## 7.3 Financial Responsibility

To protect the facility and to prevent future problems, the best thing to do is to get a signature on a financial guaranty statement at the time of service. Before making someone financially responsible, consider the following:

- Anyone signing the guaranty must be aware of the fact they are accepting financial responsibility.
- Anyone signing the guaranty must be considered “competent” at the time they sign. Minors, mentally ill, or anyone under the influence of drugs or alcohol would not be considered competent.

With a guaranty statement properly signed and dated, the question of who is responsible is eliminated.

**Who should sign the financial guaranty?**

An individual who accepts financial responsibility on behalf of the patient.

Examples are:

- **Mentally competent adult** – Patients who are of legal age (18 years old) or emancipated and are mentally competent.
- **Mentally incompetent adult** – If patients are over the legal age, but considered mentally incompetent, the financial guaranty should be signed by the patients' parents or legal guardian.
- **Married patients** – If services are for the wife, both husband and wife are responsible, so either one can sign or you can collect from either of them. If the services are for the husband, in some states you cannot hold the wife responsible for payment without her signature, so she should not be listed as guarantor if she did not sign the financial guaranty.
- **Divorced or separated patient** – The wife should always be listed as her own guarantor and the husband as his own.
- **Minor children** – Both parents are financially responsible for payment of their minor children's bills, so either parent can be listed as guarantor, and you may collect from either parent.

For non-beneficiaries, the financial guaranty signature shows who is accepting financial responsibility for the patient's bill. Since non-beneficiary patients accepting medical services at your facility are financially responsible, balances may be collected without signature. However, this does not mean a guarantor's signature is not important.

Often circumstances occur, preventing providers from getting the necessary financial guaranty signature. Even if you do not have a signature, non-beneficiary patients are still liable for payment under the theory of implied-in-law contract or quasi-contract. If non-beneficiaries receive services and do not pay for them, they would benefit unjustly at the provider's expense. This is why, if non-beneficiary patients accept medical services at your facility, it is implied that they accept responsibility.

## 7.4 Collection Process

There are five financial control points in the collection process:

### 1. Before services are rendered

Includes obtaining or verifying patient demographic and eligibility information through telephone calls or online processes prior to the scheduled appointment. Review payment requirements with non-beneficiaries,

### 2. During the registration process

Includes obtaining and updating patient information and signatures on required documents (AOB, MSP, etc.) by the Registration staff or Benefit Coordinator.

### 3. During the visit

Includes completing the required charge tickets and documentation by the nurse assistant, nurse practitioner, nurse, or provider during the course of their conversations.

### 4. At discharge

Includes information obtained by and through the discharge process or by the Appointment clerk.

### 5. Collection follow-up

This would include information obtained by Billing, Pharmacy, and/or Collection staff.

The Registration staff plays a significant role in the first three control points. By emphasizing the first three, the facility can easily improve information gathering and full collection of accounts.

Information obtained from patients is the best way to get the required data. While they are talking with the Registration staff or Benefit Coordinator, patients are more willing to communicate because they are in need of services and are more inclined to provide information and/or to pay (non-beneficiaries) to be certain the services are received. Once patients receive treatment, the urgency is gone, and the bill does not seem that important anymore.

### 7.4.1 Collecting Co-Pays, Deductibles

If the non-beneficiary patient has insurance and the facility plans on filing the insurance, you need to collect the co-pay before the patient leaves the office.

To make collections easier:

- Put up a sign stating that all co-pays are expected at time-of-service unless other arrangements have been made. Visibility is important, as is keeping patients informed.
- Don't underestimate patients. Most expect to pay their co-pay at the time of their visit, but if you don't ask for it, they won't pay.
- The co-payment amount usually can be found on the insurance card or by calling the insurance company. It is better to take a minute to make the call than to simply assume no co-payment is required.

Even though there is no contractual obligation to collect coinsurance at the time of service, doing so is a huge improvement in the overall financial health of the facility. If the Registration or designated Collection staff can be convinced to collect consistently, account receivables will improve.

Reimbursement for the service or for co-payments should be in the form of cash, check, credit card, cashier's check, money order, or traveler's checks. Stamp all checks with the health care facility's endorsement and the time of receipt.

*Do not accept:*

- Two-party checks
- Postdated checks
- Multiple-party checks
- Checks written in excess of the amount owed

## 7.4.2 Credit Card Helpful Hints

Having patients use their credit cards to make payments is a proven way to increase collections. Many patients may not have cash to pay their bill in full, but usually, they do have credit cards available.

However, convincing patients to charge their bills can be a difficult task. Registration staff may not know what to say; designated collectors are afraid to offend patients; and others are overcome by patient excuses and objections. To encourage paying for medical services with a credit card,

- **Put signs up** – You need to have signs showing credit cards are accepted for payment of patients' bills. Post them where they are visible to patients.
- **Put it on your statements for Non-Beneficiaries** – Statements should make it clear that credit cards are accepted.
- **“Sell” credit cards** – Patients don't always pay attention to signs, statements, or policies, but Registration staff, Benefit coordinators, collectors, or others can remind the patients that credit cards are accepted.
- **Convince them it's the right thing to do** – Many patients don't want to put their medical bill on their credit card. You need to convince them that paying now is the right thing to do.
- **Overcoming their excuses** – Patients will offer many excuses for not paying by credit card. Be prepared to overcome these excuses.
- **Get authorization at registration** – Some patients are reluctant to pay at the time of service because they want to wait until their insurance pays. You can have these patients sign a credit card preauthorization form. This form gives you permission to charge the patient's balances to their credit card.

### 7.4.3 Collection Guidelines for Non-Beneficiary Payments

*Collecting at time-of-service is a crucial practice many facilities use inconsistently, if at all.*

#### **Before the visit**

When setting up an appointment for a non-beneficiary, it is always a good idea to discuss the procedures that will be done immediately during the visit, followed by the charges associated with the visit. Non-beneficiary patients need to know about these charges and that payment is expected at the time of service.

#### **Prior to seeing the provider**

An effective tool to determine whether a non-beneficiary has come in prepared to pay is the check-in process itself. Non-beneficiaries are required to check-in prior to seeing a provider. This is expected and most patients do so without any prompting.

Always review the patient's insurance card for co-pay information and collect any appropriate co-pays and deductibles at check-in. Add verbiage on a Non-beneficiary payment policy form, and include the customary standard return check fee.

At this point you will have an understanding of whether this patient intends on paying.

#### **After the visit**

Even though the patient indicated at the time of check-in that he/she would be able to pay for the visit, some patients, after seeing the provider, will try to tell you that they cannot pay in full today. You should ask them for other means of payment.

The following table shows some of the most frequent excuses and appropriate responses.

| The Excuse:   | The Response:   |
|---|---|
| “I never had to pay at the time of service before with my regular doctors.” | “I understand your concern. Paying at the time of service helps us to avoid additional administrative cost, which saves you money. Plus, it lets you take care of your payment now rather than worry about a bill later. Would you like to pay by cash, check, or credit Card?” |
| “My insurance will pay.”  | “We verified your insurance coverage and the representative noted a deductible/copayment obligation that is your responsibility. Would you like to pay by cash, check, or credit card?”   |
| “I didn’t bring my checkbook.”  | “That’s OK; we also accept cash and credit cards.”  |
| “Can I pay over time?”  | “You can pay half now and the remaining half in 30 days. How would you like to handle your payment?”  |
| “I saw the doctor for only five minutes. Why is the bill so high?”          | “The visit is based on the care and counsel, not the time with the provider.”   |
| “You seem more worried about the bill than my care?”                        | “I assure you we are concerned about your care first. Payment for that care ensures that we can continue to provide the quality treatment you and other patients expect.”   |
| “Just send me the bill.”  | “I’m sorry; we can no longer delay collecting payments.”  |

Of course, if the patient really did not bring any money, then you would have to let him/her leave without paying. You cannot make a patient pay, but you can make it difficult for them not to pay.

#### **7.4.4 Guidelines for Deceased Patient Collections**

There are some legal implications to consider when collecting after a patient has died. Here are some guidelines:

- Check for all outstanding accounts for the patient. Note that the patient is deceased on all files. Change bill to read “Estate of John Do.”
- Find out the date the patient died. If it was recently, you may want to stop all normal collection steps. You should allow at least four weeks before resuming collection activity.
- You can verify the death by checking the obituaries or contacting the registrar of deeds office. Be sure to obtain the next of kin, if you do not have this information already.
- Contact the nearest relative or the county probate office to find out if there is an estate left and the name of the executor or attorney handling it. It is usually best to call the probate office instead of a relative because the relative may not honestly disclose estate information.
- If the balance warrants and there are sufficient assets, file a claim on the pending estate. You do not need an attorney to do this. The executor or your county probate office can give you necessary forms and instructions. Many states have time limits for filing on estates.
- If there is a surviving spouse, contact the spouse for payment. Husbands are responsible for payment of a deceased wife’s bill. In a few states, a wife may not be legally responsible for payment, but many will pay out of honesty and loyalty.

#### **7.5 Collecting Insurance Reimbursements**

Insurance companies are in the business of making and keeping money, and if they can get you to give up your claim to their money out of frustration, they're happy. Some insurance policies seem to lose half of their initial claims and deny the other half, so don't be surprised that you need to hassle them to pay you. But don't be discouraged, either.

The process of following up with insurance companies is straightforward:

- Contact them regarding the outstanding claim between 45-90 days,
- Determine what is missing or why the claim has not been paid,
- Send any additional information requested to include, if asked by the insurer, a duplicate copy of the claim, and
- Document the entire conversation in the patient record.

In the event the insurance company does not respond in a timely manner or is non-responsive, a detailed process needs to be followed.

- The billing staff needs to call the insurance company to verify that the claims have been received. Ask specific, detailed questions. If the individual is not responding to the questions, request to speak with the supervisor. Document all telephone calls and include the date, time of the conversation, the name of the individual at the insurance office, and the resolution or outcome. This information will be supported in case the insurance company questions timely filing limitations.
- If the claim is lost and the insurer has no record, resubmit a duplicate claim.
- If the claim(s) has been received and is pending receipt of additional information, note exactly what is needed for the claim to be processed.
- Additional information requested should be sent to the insurer in a timely manner.
- If payment has not been made on the agreed upon date, follow-up with the insurer.
- Follow-up when a message has been left and the insurance representatives has not returned a call.
- Unpaid claims over 120 days should be forwarded to a collection service, such as Transworld Systems, for further collections.
- Follow-up on inpatient accounts first – these are usually the accounts with more services and cost.
- Build a file on insurance companies. The file should include company name, address, phone number, names of individuals, and titles.
- Involve the patient if you are unsuccessful with the insurers. This should be done as a last resort.

Continue to follow up with the insurance company until the claim has been adjudicated.

### 7.5.1 Guidelines for Claim Resubmissions

It is not a good idea to routinely send a duplicate claim form without conducting a manual review of the claim. The insurance system will reflect that they have two claims for the same date, which may appear to be a duplicate.

To avoid confusion at the insurance company, all follow-up claims should be identified as *resubmissions* or *tracers*.

## 7.6 Transworld Systems Debt Collection

Transworld Systems is in the business of profit recovery and has an arrangement with IHS nationally to provide follow-up inquiries to insurance companies for any facility in need of their service. With the state laws in effect, insurance companies should pay claims within 30-45 days; however, their stipulation is when they receive all the information needed from the provider or facility. This delay tactic results in around 20% of the claims not being processed in a timely manner.

Transworld is contracted to generate from one to a maximum of five demands to the insurance carrier at a fixed flat fee per claim, for those claims over 90 days old. In each communication the insurance company is instructed to pay and communicate directly to the medical facility. All monies, calls, and correspondence still pass through the medical facility where the information regarding the claim is kept. In addition, the Transworld process is integrated with the IHS RPMS system, enabling them to obtain bills from the facility electronically.

Transworld's intent is to resolve from 60-to-95 percent of the claims in the over 90-day category, enabling the medical facility to complete the revenue cycle and concentrate their collection efforts with insurance companies on claims less than 90 days old.

Since many insurers state in their policies and by-laws that they must respond to third-party collection agencies or attorneys within a set number of days, Transworld effectively utilizes these regulations to their advantage. Many of their claims are reviewed more timely, at a higher level, and if the insurer needs some specific information, they will call or write stating exactly what is needed. The end result is that the Collection department is working more productively, researching and providing the information needed versus making follow-up collection calls.

In summary, as a debt collection firm, Transworld rides on the regulations stated in the Federal Fair Debt collection Practices Act that “all portions of the claim shall be assumed valid unless disputed within 30 days”. The insurance companies do not want to be held responsible for 100% of the claim, and secondly, the insurance company must comply with the Federal law. Therefore, these outstanding claims are handled and resolved within the 30-day timeframe.