Professional standards and patient empathy ease burden of payment collection

Delivering quality healthcare doesn’t end when a patient leaves the postanesthesia care unit. It continues until the final installment of the bill is paid. It continues even when the payment is overdue, missing, or refused.

To stay in business, an ambulatory surgery center (ASC) must collect the fees it has earned. It is important to know how to do this efficiently, effectively, and as quickly as possible. However, it is equally important to respect the concerns and circumstances of patients. For one thing, it is good business to leave a customer with goodwill and the intention to return or to refer others to the ASC. For another, legal and professional standards mandate a sensitive and compassionate approach to healthcare collections.

Ask first

There is one simple rule for successful payment collection: Ask the patient to pay on admission, before the procedure begins. For patients without insurance, or those with copay obligations, it makes sense to have them write a check up front.

However, ASCs frequently don’t ask for advance payment. “Too often, ASCs won’t ask for money,” reports Trae Christian, an account executive with the collections firm Frost-Arnett in Nashville, Tennessee. “They need a strong front office to collect more money up front. If they collect it then, they will use me a lot less.”

It is common for ASCs to agree to payment plans. However, after the surgery, some patients may stop payments before the bill is settled. “Physician owners tend to be trusting and optimistic,” Christian says.

The debt may balloon if the insurance company denies the ASC’s claim and the ASC seeks compensation from the patient. That is the most common reason patients cannot afford to pay their entire bills. As part of patient selection, many ASCs do not accept patients who have no insurance at all, instead referring them to a hospital.

Some patients, Christian notes, don’t understand the charges or they expect the insurer to pay the entire amount. Others, he adds, understand the system well and know that a small creditor such as an ASC will eventually write off the unpaid charge.

At Fremont Health Surgery Center in Fremont, Nebraska, the challenge of collecting overdue payments has lingered even long after the ASC was acquired by a local hospital. Although new owner Fremont Health’s billing department handles current cases, the ASC is still following up on accounts from before the February 2014 consolidation. According to administrator Tracy Hoeff-Hoffman, Fremont tries to collect payments up front, but if a patient cannot pay, the facility will try to arrange credit or financing. “We would not deny care if someone couldn’t pay,” Hoeff-Hoffman says.

Dupont Surgery Center in Louisville, Kentucky, contacts patients before admission and verifies their insurance, often using secure websites operated by large insurers. Business office manager Cheryl Barbour and her staff ask patients to arrive with full
self-pay, deductible, or copay amounts. “If I want to get paid, I do all the legwork,” Barbour says.

When the patient cannot pay 100% up front, Dupont offers payment plans. If the patient does not follow through, Dupont sends three statements, and a staff member calls the patient. If the patient misses the next deadline, Dupont sends a letter stating that failure to pay within 10 days will result in referral to a collection agency.

**Send in the pros**

Christian estimates that at least half of ASCs, and probably more, outsource difficult collections. Some work regularly with third-party collectors.

It is important to choose a third-party collector that specializes in healthcare and knows the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

Typically, the collection agent will call or write to the patient, Christian says. It’s helpful if the ASC provides accurate contact information and documentation such as previous demand letters and payment history.

The agent then explains the contents of the bill and the patient’s responsibility. If the patient cannot afford to pay, the agent proposes a payment plan.

Treating the patient with respect and consideration is important. Patients are more likely to follow up with a payment plan if they understand the reason for the charges and if the plan accommodates their financial constraints.

**Compassion is critical**

Professional ethics as well as state and federal laws dictate how collections personnel treat patients.

Members of ACA International, the Association of Credit and Collection Professionals, are bound by an ethics guide that contains the following pledge: “I believe every person has worth as an individual. I believe every person should be treated with dignity and respect. I will make it my responsibility to help consumers find ways to pay their just debts. I will be professional and ethical. I will commit to honoring this pledge.”

ACA International members are required to make efforts to establish the validity of debts. If a consumer asks for verification, the collector must stop collection activity until verification is provided. If the collector cannot verify the debt, the debt must be removed from the consumer’s credit report, and the collector must notify the client or organization that transferred the account that collection was terminated. In other words, a consumer cannot be asked to pay a disputed debt.

If the consumer or collector suspects identity theft, the collector must investigate the possible fraud and comply with any requirements to notify law enforcement.

The ethics code specifically forbids any effort to deceive, harass, or threaten a consumer. ACA International members also are required to report other members who violate this code.

**Keep the balance**

For collectors who contract with ASCs and other healthcare providers, more stringent rules apply. ACA International has a separate code of conduct for collections from patients. These guidelines, described as voluntary, follow provisions of HIPAA, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, and charity programs for healthcare.

The code of conduct specifically notes that, from the perspective of customers, collectors are part of the healthcare system and representatives of the provider.

For firms with healthcare clients, ACA International guidelines call for developing
The Medical Account Resolution Process

Goal: We believe that most patients want to resolve their medical accounts in a responsible manner. However, one of the challenges facing them is the highly variable processes used to resolve accounts, which contributes to confusion. Therefore, our goal is to identify a common set of account resolution best practices that align with HFMA’s Patient Friendly Billing Principles and emerging federal requirements to simplify the process for patients. These best practices should be consistent for widespread industry adoption, leading to improvements in patient experience, financial performance, and ensuring a fair collection process for patients and providers. A key component of this is educating patients about the availability of financial assistance programs and the account resolution process, which begins prior to patient registration as prescribed by HFMA’s Patient Financial Communications (PFC) Best Practices. This workflow begins with the initial statement and assumes all Patient Friendly Billing and Patient Financial Communications Best Practices have been observed.

Post-Service Account Resolution: Part 1

Medical Account Resolution Efforts

Continued From Pre-Service/Time of Service

Patient’s Account Is Screened for:
- Primary/Secondary Payer for Billing
- Accurate Payment Made/Posted from Payers
- Discounts for Necessary Care Provided to Eligible Uninsured
- Eligibility for Public Programs and Exchange-Based Coverage
- Bankruptcy
- Financial Assistance Programs Summarized in Plain Language and Applied According to Provider’s Board Approved Policy

A Clean Bill Is Sent to Patient for Patient’s Portion of Financial Responsibility for Services Rendered

Small Balance Resolution Options:
- Resolve the Account Internally (see Provider Account Resolution Efforts)
- Send to Early Out Business Affiliates
- Administrative Write-Off of Account

Post-Service Account Resolution: Part 2

Resolution Process for All-Risk Accounts

Account Goes to Collection Agency
- Patient Granted 100% Financial Assistance or Pays
- PROCESS STOPS

Collection Agency Efforts Depend on Provider Board-Approved Policy
- Options May Include:
  - Screening or Scrubbing: Insurance, Financial Assistance Program Eligibility, Bankruptcy, Deceased, Data Integrity, Proven Pay Possibility to Pay, Asset Verification

Patient Does Not Pay in Full
- Balance Remains on Account

Possible Options for Provider Account Resolution Efforts
- Insurance Verification/COBRA Eligibility
- Eligibility for Public Programs
- Bankruptcy Screen
- Data Scoring for Financial Assistance/ Payment Plan Development
- Presumptive Score Review
- Reasonable Efforts to Determine Eligibility for Financial Assistance Programs Undertaken
- Installment Plans
- Third Party Loans from Reputable Lenders
- Calls/Letters

As recommended by the HFMA Medical Debt Task Force, the following suggestions are intended to provide best practices to support fair account resolution policies and procedures. This process does not require duplication of efforts at the front end of the revenue cycle where HFMA Best Practices for Patient Financial Communications have been adopted and consistently applied.

quality assurance programs as well as training and supervising employees in the ethics code and healthcare requirements. That means helping the patient understand the bill and communicating with the provider about the case and collection activities.

The professional relationship should be clarified in writing, including permissible collection methods and fees. Fees are generally based on a percentage of the collected amount. The collector should also have permission from the healthcare provider before selling or transferring the account to another agency; the second agency might not be subject to the guidelines or skilled in healthcare collections.

Follow debt collection guidelines

Although ACA International’s ethics code and healthcare guidelines cover its 5,000 members, some feel stronger rules are needed to cover all collections professionals. Chi Chi Wu, a staff attorney at the National Consumer Law Center (NCLC), says the Consumer Financial Protection Bureau (CFPB) should step in with regulations to govern all healthcare collections.

In a paper published in 2014, she cites studies showing that in 2012, 41 million Americans were contacted by third-party agencies to collect medical bills, and that 75% of these debtors had been insured before treatment.

“Much of the medical debt that actually harms consumers is in the hands of debt collectors, not healthcare providers,” she notes.

Many of Wu’s recommendations echo ACA International guidelines, such as giving patients a chance to dispute charges before posting them to credit reports, avoiding harassment, and recognizing that low-income patients may be eligible for charity care.

Following publication of the NCLC paper, ACA International CEO Patrick Morris issued a statement saying the credit industry supports working with patients to improve access to healthcare, but rejecting the proposal for CFPB oversight. Morris argues that ACA International has worked with the Healthcare Financial Management Association (HFMA) to develop best practices for collections. “We believe the best practices are balanced, fair, and reasonable, and provide for appropriate protection for patients,” Morris says.

The HFMA’s medical debt collection task force has published a set of guidelines that include detailed steps in following up on delinquent accounts (sidebar, p. 29). The guidelines stress education of patients and shared responsibilities in resolution of debt. They include a list of applicable laws.
Understand the insurance system

There are other specialists that can help maximize collections from insurers. One is ERISA Revenue Solutions in Beloit, Wisconsin. The Employee Retirement Income Security Act of 1974 (ERISA) applies only when an insurance policy is part of an employee benefit, explains Lea Fowler, director of claims recovery. The law is complex, and Fowler says even billing companies are not always aware of how it applies to healthcare payments.

For example, she says, “If you are an out-of-network provider [like many ASCs], you are legally entitled to receive payment directly instead of checks going to patients, as long as you have a properly signed authorization of benefits.”

Another little known fact, she says, is that whenever an insurer does not pay the full amount billed, the provider has the right to appeal.

“I just think it’s important that out-of-network providers know there are legal ways to get their money without having to constantly chase patients as they are sometimes led to believe,” she explains.

Fowler says she knows of ASCs that routinely receive only about $17,000 for every $100,000 bill they submit to insurance companies, even after deducting copays and out-of-network discounts.

“That leaves the patient with an $83,000 bill,” she says. “Payers need to be brought down a notch or two.” In fact, she says, ASCs have begun suing insurers for denied claims, and the Department of Labor, which administers ERISA, has been supporting their efforts.

The problem for ASCs, Fowler explains, is that much of their business is with insured patients, but not as part of insurance networks. For every bill they submit, the insurer subtracts 40% to 60% before paying the claim, without explaining the rationale behind the final payment amount. When the insurer underpays, the ASC may go back to the patient for the rest.

ASC managers and owners tend to focus revenue strategies on Medicare, lobbying to raise reimbursement levels and extend coverage areas. Yet they rarely try to recover compensation from private insurers.

The reason, Fowler says, is that they are unaware of other options for recovery. Billing departments accept the payment and move on without trying to recover the full amount.

“You have the right to appeal anytime you get less than what you bill the insurer, minus the patient’s responsibility specified in the health plan,” she tells them. (As with any group, she notes, there are always a few ASCs that do understand their rights and raise prices to take advantage.)

Fowler and her colleagues at ERISA Revenue Solutions are not lawyers. They have gained expertise by studying ERISA cases and documents, and they work to help clients understand their rights and responsibilities. Here is her advice to ASCs treating insured patients:

- When the patient comes in, have them sign an ERISA-based authorization of benefits forms (see sidebar, p 30). This form gives the provider the same right to appeal as the patient, and covers all subsequent procedures until revoked in writing.
- Have the billing department review every bill, comparing the expected payment with the insurance explanation of benefits. When payment arrives, if there is any discrepancy with the amount received, file an appeal. “Too many ASCs don’t know how to appeal, or that they have that option,” Fowler says. “Even billing companies don’t know.”
• The insurer has 30 days to respond to the appeal under ERISA. Most will deny the first appeal. The ASC may continue to appeal until the insurer pays, agrees to a settlement, or determines that the ASC has exhausted its administrative remedies.
• Finally, it may be worthwhile to take the insurer to court. The ASC must weigh the expense of finding an attorney with insurance and ERISA expertise and of filing suit in federal court, where all ERISA cases appear.
  Even if the ASC does not pursue the legal alternative, carrying the appeal through one or more steps will have lasting benefits, Fowler says. The patient whose final bill is lowered will be grateful. Even if the effort is unsuccessful, the patient will appreciate it.
  “By advocating on the patient’s behalf, you may save them money. It’s good public relations,” she says. ❖

—Paula DeJohn

References