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Origination	10/31/1995
Last Reviewed	9/14/2022
Effective	9/14/2022
Last Revised	7/9/2020
Next Review	9/13/2024
Owner	BRETT Klein: Manager, Insurance Collections
Department	Revenue Cycle-Patient Financial Services

Credit And Collection Policy

Purpose:

Consistent with its mission, the Hospital must seek payment for the services it renders to its patients. As such it is the policy of UPMC Cole to impose reasonable and customary fees for the services it provides. The Hospital expects its patients to honor these charges by paying directly or indirectly through an insurance program in a timely manner. The Hospital has a financial assistance policy, discount policy and self-pay payment plan policy to assist patients with their financial obligations to the Hospital. There is a sliding fee program as well as the self-pay payment plan policy to assist patients with financial obligations to the Physician Network.

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Definitions:

Hospital – UPMC Cole

Physician Network – Hospital employed physicians or contracted physicians who have assigned billing and collection rights to the Hospital.

Customer Service – UPMC Cole Financial Counselors

PA Medicaid – Pennsylvania Medical Assistance Program

Final Notice – the last statement to be received prior to being turned over to a collection agency.

Medicare Cost Report – Annual Medicare Cost Report to determine Hospital Cost

PFS – Patient Financial Services

Scope of Policy:

All services rendered by the Hospital and its Physician Network.

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Policy:

1. All patient balances are first billed to the primary and secondary insurance carriers using the appropriate billing methods and protocols as defined in the contracted agreements. Payments are posted to the appropriate patient account and contractual adjustments are reviewed and verified to the remittance.
2. Efforts are made to identify patients who may be eligible for financial assistance in accordance with the Hospital's Financial Assistance policy or the Physician Network sliding fee scale prior to the statement process when possible.
3. For self-pay account balances after insurance as well as pure self-pay patient balances, statements are mailed to the patient/guarantor monthly:
    a. If the patient/guarantor contacts Customer Service and cannot pay, it is recommended that the patient applies for PA Medicaid. If denied PA Medicaid, the patient is encouraged to apply for financial assistance as defined by the Hospital's Financial Assistance policy.
    b. Payment arrangements are made available to the patient/guarantor through the self-pay payment plan policy by contacting Customer Service.
    c. Discounts are offered to pure self-pay patients through the Hospital's discount policy by contacting Customer Service.
    d. If the patient/guarantor has numerous Hospital account balances, it is recommended that the account balances be combined into one account.
4. If no payment is received, each succeeding statement message becomes stronger up to the fourth statement, which is a Final Notice.
5. If no payment is received, a Final Notice has been sent and it is more than 120 days from the payment/denial date of any secondary payor, if applicable, or the primary payor if there is no secondary payor, the account will be transferred to bad debt and be referred to a collection agency to continue collection efforts.
6. An account will remain with a collection agency for 180 days for balances up to the Medicare inpatient deductible, and indefinitely for accounts with balances greater than the Medicare inpatient deductible. Accounts that are equal to or less than the Medicare inpatient deductible will be returned to the Hospital after 180 days and will be deemed uncollectable. Medicare allowable uncollectible accounts will be claimed as bad debt on the Medicare Cost Report.
7. Account balances are reviewed monthly as part of the accounts receivable review process. Minimum work efforts to insurance carriers are as follows:
    a. Balance in excess of $5,000 – unlimited
    b. Balance between $1,000 - $5,000 – 4 calls
    c. Balance between $500 - $1,000 – 3 calls
    d. Balance between $100 - $500 – 2 calls
    e. Balance under $100 – 1 call
8. Amounts that remain unpaid after minimum work efforts have been met that have timed out

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based on contract language will be written off using adjustment code AEX – all efforts exhausted.

9. When credit balances are identified, the accounts are researched to understand appropriate resolution. When appropriate, refunds are processed to the insurance companies or to the patient/guarantor.
10. Account write-offs that occur as the result of authorizations, referrals, timely filing requirements, medical necessity, etc will be processed according to definitions established in the job aid.

Related Policies/Procedure: Financial Assistance Policy, Discount Policy, Self-Pay Payment Plan Policy, Sliding Fee Program
Job Aids Desk Top References, Adjustment Code Job Aid

Authoritative Reference(s):

"N/A"

Previous Review & Revised Dates:

Original Date:10/31/1995
Review Date:06/18/07, 9/25/2009, 01/13/2012, 07/08/2020
Revision Date:9/25/2009, 07/08/2020

Approval Signature(s):

Manager, Insurance Collections	Brett Klein	**Date:** 07/08/2020
CFO	Ron Rapp	**Date:** 07/08/2020

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All Revision Dates

7/9/2020, 7/9/2014, 9/25/2009

Attachments

Credit and Collection Policy.pdf

Approval Signatures

Step Description	Approver	Date

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CFO	RONALD Rapp: CFO, NCPA Ring Facilities	9/14/2022
Manager, Revenue Cycle	BRETT Klein: Manager, Insurance Collections	9/12/2022
Gatekeeper	Christina Avilez: Admin Assistant - Senior	9/12/2022

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