COLLECTION TRAPS

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OVERVIEW

Goal: to answer some questions and clarify misconceptions about collection issues.

Tips

- Financial responsibility
- Collection practices
- Prompt pay laws
- Medical liens
- Financial aid policies
- Collection agencies
- Lawsuits
- Executing on judgments

Traps

- Conditioning treatment on collections
- Payer tricks
- Legal limits on collection processes
- Discounts on bills
- Paying patient premiums

COLLECTING FROM PATIENTS

PATIENT'S RESPONSIBILITY

- Competent patient who agreed to care is generally responsible for payment.
  - Contract
    - Ensure patient signs financial responsibility form.
    - Ensure patient consents to care provided.
  - Equitable benefit conferred
- Patient may not be responsible for cost if:
  - Lack of consent or agreement for treatment.
  - Provider agrees otherwise, e.g.,
    - Contract with insurer or managed care program that limits ability to bill patient.
    - Participate in govt program that limits ability to bill patient, e.g., Medicare, Medicaid, grants, etc.

MINOR'S RESPONSIBILITY

- Unemancipated minor generally lacks legal capacity to contract for services and may disaffirm contract. (See WS 14-1-101(d))

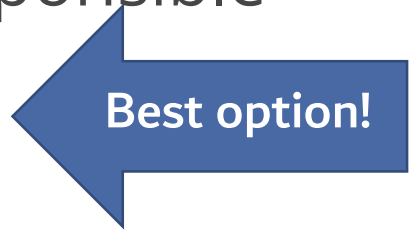
- What if minor may consent to their care? (See WS 14-1-101(c)).

PARENT'S RESPONSIBILITY

- Parents are generally liable for necessary care rendered to minor children. (See WS 14-2-204(a))
  - Express contract
  - Benefit confirmed
  - Statute.
- Entity furnishing care or support of the child may sue for past and future medical support. (See WS 14-2-204(b))
- Remember: make sure you have valid consent to treat minor, or you may be sued for battery.

THIRD PARTY RESPONSIBILITY

- Other third parties are generally not responsible for patient's care unless:
  - They agree to be responsible.
    - Obtain agreement for financial responsibility.
  - Law or agreement makes them responsible for cost of care.
    - E.g., third party insurers, guardians, persons in custody of state, etc.
  - Provide care at their request and for their benefit.
    - But this is "iffy"; better to obtain express agreement.
- Ensure that proper consent for treatment is obtained from authorized person.



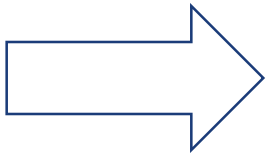
DISCLOSURE TO OBTAIN PAYMENT

- **Does the HIPAA Privacy Rule permit a covered entity or its collection agency to communicate with parties other than the patient (e.g., spouses or guardians) regarding payment of a bill?**
- Answer: Yes. The Privacy Rule permits a covered entity, or [its] business associate … (e.g., a collection agency), to disclose protected health information as necessary to obtain payment for health care, and does not limit to whom such a disclosure may be made. Therefore, a covered entity … may contact persons other than the individual as necessary to obtain payment for health care services. …However, the Privacy Rule requires a covered entity … to reasonably limit the amount of information disclosed for such purposes to the minimum necessary, as well as to abide by any reasonable requests for confidential communications and any agreed-to restrictions on the use or disclosure of protected health information.

(https://www.hhs.gov/hipaa/for-professionals/faq/266/does-the-privacy-rule-permit-a-covered-entity-to-communicate-with-other-parties-regarding-a-bill/index.html)

COLLECTION PROCESS

- Informal collection (patient agrees)
  - Payment up front
  - Invoices/letters
  - Personal contacts
  - Guarantors
  - Payment plans
  - Collection agency
  - Collection attorney
  - Consensual lien
  - Consent judgment



- Formal collection (patient refuses)
  - File lawsuit
  - Obtain judgment
  - Record judgment
  - Execute on judgment
    - Garnishment
    - Attachment
    - Foreclosure

PAYMENT POLICIES

- Adopt, publish, and enforce payment agreements and policies.
- Discuss policies with patient up front.
  - Payment is due (including copays) at the time of service unless alternative agreement prior to treatment.
  - Practice will file insurance claims as accommodation to patient, but patient or guarantor remains responsible for payment.
    - Beware unintended consequences discussed below.
  - Statements are mailed at least every 30 days.
  - Balance sent to collections after [90-120] days.

PAYMENT POLICIES

- Specify additional charges and fees that may apply if allowed by applicable law and payer contracts.
  - Late charges.
  - Returned checks.
  - Missed appointments.
  - Collection costs and attorneys fees.
- Give patient, personal representative or guarantor a copy of payment policies.
- Confirm that signature on registration constitutes acceptance of terms of financial policies.
  - Creates contractual obligation.

ADDITIONAL CHARGES

- Laws may limit charges.
- Medicare, Medicaid, and payer contracts may limit your ability to charge certain fees.
  - May not be able to charge late fee or other charges because this would exceed allowable charge.
  - May be able to charge outpatient for missed appointment if bill patient directly, not Medicare. (*See* MedLearn dated 11/12/14, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5613.pdf)

CONDITIONING SERVICES ON PAYMENT

- May generally decline services for nonpayment except:
  - EMTALA, if you are a hospital and participate in Medicare.
    - Cannot delay treatment to inquire about payment. (42 CFR 489.24)
    - May still attempt to collect after treatment provided.
  - Contract obligation (e.g., managed care contracts, grants, etc.).
  - Charity care obligations (e.g., public entities, 501(c)(3), grants, etc.). (See, e.g., WS 18-8-106)

PATIENT ABANDONMENT

- May generally decline services for nonpayment except:
  - Do not abandon the patient!
    - May not "improperly terminate a physician-patient relationship." (*See* WS 33-26-402(a)(xxvii(N); *see also id.* at (C))
    - If assumed patient's care, must give patient notice and time to find new provider before terminating care (e.g., 30 days).
    - Provide necessary care in meantime.
  - Penalties
    - Adverse licensure action.
    - Patient lawsuit for damages.

REFUSING TO RELEASE RECORDS

- May not refuse to release records until account is paid in full.
  - Per HIPAA, patients have a right to obtain a copy of their medical records with very limited exceptions.
    - May charge the patient a reasonable cost-based fee to provide a copy of their medical records.

  (45 CFR 164.524)
  - Possible adverse licensure action? (See generally(See WS 33-26-402(a)(xxvii))

FINANCIAL HARDSHIP POLICIES

- Establish and refer to financial hardship policies.
  - May help avoid Anti-Kickback Statute ("AKS") or Civil Monetary Penalties Law ("CMPL") violations, e.g.,
    - Waiving copays or deductibles.
    - Writing off bills.
  - ACA requires 501(c)(3) hospitals to establish financial assistance policies meeting certain requirements. (IRS 501(r))

CALLING PATIENT

- Be professional.
- Telephone Consumer Protection Act ("TCPA")
  - Generally prohibits prerecorded calls to a residence or prerecorded or autodialed calls to a wireless number without recipient's prior express consent.
  - Exempts prerecorded healthcare related calls to residential and likely wireless numbers, but exemption likely does not apply to calls about account or by creditors.

(47 USC 227; 47 CFR 64.1200 et seq.; FCC Order 12-21).

- To be safe, obtain consent if you intend to use prerecorded or autodialed calls for collection purposes.

DEALING WITH GOVT PAYERS

- When participate in govt programs (e.g., Medicare, Medicaid, TriCare, grants), must comply with contractual and regulatory requirements.
  - Coverage.
  - Balance billing.
  - Payment.
  - Repayment.
- *Know the state and federal rules!*

DEALING WITH PRIVATE PAYERS

- It's a matter of contract!
  - If you agreed or are "in network", you are bound by the terms of payer agreement.
  - If you didn't agree or are "out of network", then you are generally not bound by private payer's terms.
  - But beware of unintentionally agreeing.

BALANCE BILLING

- If you have not contracted with payer, you may generally bill patient for balance due.
- If you contract with payer or otherwise agree to accept payer's terms, payer may limit balance billing for covered services.
  - Check contract.
  - May bill patient for:
    - Copayments and deductibles.
    - Services not covered by the payer contract.
- Medicare requires prior notice:
  - Part A: Hospital Issued Notice of Noncoverage ("HINN")
  - Part B: Advance Beneficiary Notice ("ABN")

UNINTENDED ACCEPTANCE OF INSURER'S TERMS

- Payer may place terms or conditions on submission of claims (e.g., on insurance card, EOBs, correspondence accompanying payment, etc.), e.g.,
  - "By submitting claim to payer, agree to be bound by payer's terms and conditions."
  - "By submitting claim, agree to payment in full; no balance billing."
  - Payment or appeal process.
- By submitting claim or accepting payment from payer, provider may unintentionally agree to terms.
- Check communications with payers carefully.
- May reject terms and bill patient instead of payer.

ACCORD AND SATISFACTION

- If patient or payer tenders check or other instrument as payment in full for the debt, and provider accepts the instrument, then debt is discharged.
  - Check marked "payment in full", "settled in full", etc.
  - Letter accompanying payment stating that acceptance of payment satisfies debt.
- May avoid accord and satisfaction if:
  - Reject or return payment within 90 days.
  - Give prior notice to debtor that notice of accord and satisfaction must be given to a specific, identified person.

(See WS 34.1-3-311; UCC 3-311)

➢ Review checks and correspondence.

ASSIGNMENT

- Provider may take assignment of patient's claim against the payer.
  - Benefit: allows provider to submit claims directly to payer and receive payment directly from the payer as if provider were the patient.
  - Risk: provider becomes subject to all the limitations and conditions applicable to the patient, e.g., acceptance of payer's rates as payment in full, claims submissions, appeals, etc.
- UB-04 form assumes provider takes assignment.
- Check your payer arrangements.

ERISA EMPLOYEE BENEFIT PLANS

- By submitting claim to employee benefit plan covered by ERISA, provider may subject themselves to plan terms and conditions.
  - Plan insurer or TPA may limit payment for charges.
  - Per DOL regulations, patient or provider must appeal payment decisions through plan's appeal process.
    - Appeal process often ill-defined and complicated.
    - Provider may fail to follow process or find it too cumbersome.
  - Failure to exhaust appeal process may limit provider's ability to pursue remedy under ERISA.
- Options
  - Contract directly with plan for higher rates?
  - Bill patient directly instead of submitting claim to plan?

GUARANTOR

- May require a guarantor.
  - Generally any competent person may serve as guarantor.
  - Guarantor must generally execute written guarantee or agreement to be bound.
    - Allow recovery from patient or guarantor.
    - Do not require exhaustion of claim against patient first.
    - Include charges, fees, costs and fees.
    - Consider requiring security.

PAYMENT PLANS

- May allow patient or guarantor to pay over time.
- Require formal payment contract.
  - Written agreement
  - Promissory note
  - Security interest
  - Interest, finance charges and late fees
  - Require guarantor

PAYMENT PLANS

- Beware: regular practice of allowing payment plans—especially if set in advance—may subject provider to federal and state laws governing those who extend credit, e.g.,
  - Truth in Lending Act, 15 USC 1601; 12 CFR part 226.
  - Equal Credit Opportunity Act, 15 USC 1691; 12 CFR part 202.
  - Wyoming Consumer Credit Laws, WS 40-14-235 et seq.

PAYMENT PLANS

- Truth in Lending Act ("TLA")
  - Applies if:
    - Extend credit more than 25 times per year, and
    - Impose finance charge or enter written agreement allowing payment in more than four installments.
  - Must include disclosures per Regulation Z.
  - Penalties include:
    - $5000 fine
    - One year in prison
    - Lawsuit by consumer for damages, costs, and fees

(15 USC 1601; 12 CFR part 226)

PAYMENT PLANS

- Equal Credit Opportunity Act ("ECOA")
  - Applies to creditor who "regularly decides" whether to extend credit unless credit is—
    - Not subject to finance charge, and
    - Not payable by written agreement in more than four installments
  - Prohibits discrimination and imposes requirements in Regulation B.
  - Penalties include civil lawsuit, punitive, fees.

  (15 USC 1691; 12 CFR part 202)

DISCOUNTS

- Beware:
  - Writing off copays or deductibles unless:
    - Documented financial need or failed collection efforts.
    - AKS safe harbor.
  - Prompt pay discounts.
    - See Adv. Op.
  - Self-pay discounts.
    - Medicare "substantially in excess" rule
    - Other considerations.
  - Professional courtesies.
    - Stark "professional courtesy" safe harbor.
    - AKS concerns.

WRITING OFF BILLS

- Beware:
  - AKS if "one purpose" is to induce referrals for items or services payable by federal healthcare programs.
  - CMPL if likely to induce beneficiary to receive items or services payable by govt programs.
  - Stark if offered to referring physicians or family members.
- May be appropriate if:
  - Document financial need or failed collection efforts.
  - AKS safe harbor.
  - Purpose other than to generate referrals, e.g., avoid or resolve claim.

WRITING OFF BILLS

- OIG suggests that hospitals (and presumably other providers) should:
  - Have a reasonable set of financial guidelines based on objective criteria that documents real financial need.
  - Recheck patient's eligibility at reasonable intervals to ensure they still have financial need.
  - Document determination of financial need.

  (OIG Bulletin, *Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills*)
- 501(c)(3) hospitals must have financial assistance policy to comply with IRS 501(r).

NONPROFIT HOSPITALS: 501(R) REQUIREMENTS

- 501(c)(3) tax-exempt hospitals must:
  - Establish a written financial assistance policy, including:
    - Eligibility criteria;
    - How patients apply for assistance;
    - How they are charged for care;
    - Emergency care regardless of eligibility for financial assistance.
  - Limit gross charges to qualifying patients to not more than amounts generally billed to individuals who have insurance.
  - Make reasonable efforts to determine eligibility for financial assistance.

(26 USC 501(r))

NONPROFIT HOSPITALS: 501(R) REQUIREMENTS

- Hospital may not engage in specified "extraordinary collection actions" prior to making reasonable efforts to determine eligibility for financial assistance, e.g.,
  - Selling debt unless conditions satisfied.
  - Credit reporting.
  - Deferring or denying medically necessary care due to unpaid bills.
  - Legal actions (e.g., lawsuit, foreclosure, garnishment, etc.), but not filing bankruptcy claim.
- Actions by others to whom hospital referred the debt (e.g., collection agencies) are imputed to hospital.

(26 USC 501(r))

PROFESSIONAL COURTESY

- Stark contains safe harbor for courtesies offered to physicians or their family members if:
  - Practice has formal medical staff.
  - Written policy approved in advance.
  - Offered to all physicians in service area regardless of referrals.
  - Not offered to govt beneficiaries unless showing of financial need.
  - Does not violate AKS.

  (42 CFR 411.357(s); 72 FR 51064)

- *But beware AKS, CMPL, and private payer contracts.*

PROFESSIONAL COURTESY

- Especially beware waiving copays, deductibles or engaging in "insurance only" billing.
  - See prior discussion.

- Offering free items or services to employees may implicate tax or employee benefit laws.
  - Benefits to employees are usually taxable.
  - May be structured to fit within employee benefit plan, but may be subject to ERISA or similar laws.

PAYING PATIENT'S INSURANCE PREMIUMS

- Provider may want to pay patient's health insurance premium or COBRA benefits to maintain insurance and net a profit.
- Beware:
  - AKS, CMPL and/or Stark if govt beneficiary.
  - Payer contract limits.

PAYING PATIENT'S INSURANCE PREMIUMS

- If paying Medicare Part B, C or D premiums:
  - AKS implicated.
  - OIG approved plan's payment of Part B premiums for ESRD patients where:
    - Patients are already receiving the services, so unlikely to induce services that might not otherwise be received.
    - No inappropriate patient steering to particular providers.
    - Patients are not coerced into enrolling in Part B.
    - Certain protections built in to protect Medicare program from additional costs.
  - OIG cautioned that it might reach different result in other circumstances.

(Adv. Op. 13-16; *see also* Adv. Op. 01-15)

PAYING PATIENT'S INSURANCE PREMIUMS

- If paying premiums for participation in health insurance exchange:
  - "HHS has significant concerns with this practice because it could skew the insurance risk pool and create an unlevel playing field in the Marketplaces. HHS discourages this practice and encourages issuers to reject such third party payments. HHS intends to monitor this practice and to take appropriate action, if necessary." (HHS Letter dated 11/4/13).
  - Limitation does not apply to:
    - Indian tribes and govt grant programs.
    - Payments made by private non-profit foundation based on defined criteria based on financial status that does not consider health status and payment covers entire year.

  (HHS Letter dated 2/7/14; 79 FR 15240)

PAYING PATIENT'S INSURANCE PREMIUMS

- If paying private insurance premiums (e.g., COBRA or other coverage):
  - Probably does not implicate AKS or CMPL unless it is tied to or induces referrals for services payable by govt programs.
  - COBRA regulations contemplate that COBRA premiums may be paid by third party.
  - Check state laws and payer contracts.
- *But stay tuned—this is a developing area of the law.*

COLLECTION AGENCIES

- Review case before sending.
  - Agency charges between 15%-50%
  - Collection efforts may prompt malpractice claim.
- May not want to send to collections if:
  - Balance is small.
  - Case involved bad outcome.
  - Case would create public relations issues.

COLLECTION AGENCIES

- Carefully select your collection agency.
  - Bad agencies reflect badly on practice.
  - Provider might be liable for collection agency's actions under—
    - Common law agency principles
    - HIPAA
    - Maybe statutes?
- Collection agencies must comply with
  - Fair Debt Collections Act, 15 USC 1692a *et seq.*
  - Wyoming Collections Act, WS 33-11-101 *et seq.*

COLLECTION AGENCIES

- HIPAA applies if—
  - Provider uses electronic transactions, and
  - Disclosure involves protected health information, including account information.
- Under HIPAA, provider may disclose protected health info to collection agency for payment purposes if—
  - Have valid business associate contract; and
  - Do not disclose more than is necessary.

  (45 CFR 164.506)

COLLECTION AGENCIES

- Under HIPAA, provider may be liable for business associate's acts or omissions if:
  - Knew or had reason to know that business associate was violating HIPAA and/or terms of business associate agreement, and provider failed to take appropriate action; or
  - Business associate is acting as the agent of the provider under the common law of agency.
    - Ensure BAA confirms that business associate is not your agent.

(45 CFR part 160)

CREDIT REPORTING AGENCY

- May report debtor to credit reporting agency, but beware—
  - Defamation claim for false reports.
    - *Student Loan Fund v. Duerner* (Idaho 1997) (awarding $2000 in damages and $100,000 in punitive damages)
    - *Hoglan v. First Security Bank* (Idaho 1991) (awarding $20,000 but reversing $200,000 in punitive damages)
  - Fair Credit Reporting Act ("FCRA")
  - Fair and Accurate Credit Transactions Act ("FACTA")

LAWSUIT AGAINST PATIENT

- If you cannot obtain payment, may consider filing lawsuit.
- Jurisdiction depends on state.
  - Small claims court
  - Trial court
- File within statute of limitations.
- But consider costs before doing so…
  - Potential retaliatory malpractice claim.
  - Bad publicity.
  - Cost and inconvenience.
  - Potentially for actually recovering money.

EXECUTING ON A JUDGMENT

- Assuming you obtain a judgment, still must collect.
  - Garnishment: served on employer.
    - Employer withholds money from paycheck and pays provider.
  - Attachment
    - Identify property that may be seized.
  - Foreclosure
    - Sell real property; collect proceeds.
- Defendant may claim exemptions.

BANKRUPTCY

- If bankruptcy filed, stop all collection activities!
  - Filing bankruptcy places automatic stay on such actions.
  - May be liable for significant penalties for violating statute.

  (11 USC 362)

BANKRUPTCY

- If bankruptcy filed:
  - Debtor should list you as creditor.
  - You should receive notice of bankruptcy proceedings.
  - Depending on type of bankruptcy, you may be able to file proof of claim.
  - Claims paid out of bankruptcy estate to creditors who have appeared, if any remaining.
  - Secured creditors may take priority.

RECOVERING COSTS AND FEES OF COLLECTION

- Require payment of costs and fees in patient financial policies/registration forms.
- State law differs re whether providers may recover costs and fees in collection actions absent contract provisions allowing same.

QUESTIONS?

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