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 improvement in the overall collection process, patient experience, and financial performance, 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

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.
Explanation of Best Practices

1) Provider must make a reasonable effort to evaluate the patient's account status and address any issues early to prevent delinquency.

2) The account resolution process should be started within 30 days of the first billing statement.

3) The provider should provide a written notice that the account is delinquent.

4) The provider should offer payment plans that consider the patient's financial ability to pay.

5) The provider should establish a formal policy regarding the use of extraordinary collections actions (ECAs).

6) Reporting an account to a credit bureau should occur only when the account is delinquent and has not been resolved.

7) The provider should establish a policy for notifying the patient of any account collection efforts.

8) Offer payment plans that consider the economic circumstances of the community.

9) Each provider should establish a formal policy regarding the use of extraordinary collections actions (ECAs).

10) All business affiliates involved in account resolution processes are required to follow the patient's wishes.

11) If an account is delinquent, communicate to the patient the potential for all board-approved ECAs (including reporting to credit bureaus) prior to initial placement. The proposed rule, this must occur 30 days prior to the use of ECAs.

12) The provider should establish a formal policy regarding the use of extraordinary collections actions (ECAs).

13) The provider should provide at least one written, 30-day notice that ECAs will be initiated.

14) Credit bureaus should be provided with an acknowledgement of accounts reported to the bureaus.

15) Collection efforts (either internal or external) should be adequately documented.

16) A provider should provide a written notice that the account is delinquent.

17) If the provider elects to sell outstanding accounts, it should require that the debt buyer abide by ABA's Financial Assistance Guidelines.

18) A provider must make a reasonable effort to ensure that the patient is aware of the FAP.

19) If patients are granted partial financial assistance, the resolution process will continue until the remaining balance is resolved.

20) Unless specifically precluded by the provider's board-approved collection policy, the provider's contract with a business affiliate, nothing in this best practice workflow should be construed to prevent business affiliates from directly contacting patients to attempt to establish third party coverage.

Presumptive Eligibility Criteria

1) Establish a comprehensive, consistent, and unbiased presumptive screening process for financial assistance programs (either full or partial discount) for both full balances or balances after insurance.

2) These models should comply with IRS regulations and pronouncements as they become available.

3) Until then, they should reflect the HFMA Principles and Practices sample, which can be found at www.hfma.org/FinancialAssistancePolicy.

4) Use a presumptive eligibility model that relies on multiple data sources and providers believe has a high degree of predictive accuracy.

5) Use provider's financial assistance program policy.

6) Use income/family size calculation.

7) Use as a screening tool during registration, financial counseling, and back-end collections.