RCO_08_119: Collections Process

Department:

Revenue Cycle Operations

Replaces Document Number:

4-11a Collections Process

Purpose:

A well-managed Surgery Center relies on the routine performance of daily functions. Account follow up is one of the integral functions that must occur on a daily basis to secure and validate reimbursement for services provided.

Persons Affected:

This policy is applicable to all teammates, business associates (contractors, consultants, temporaries, volunteers, physicians, clinicians, and other workforce members at SCA), including all personnel affiliated with third parties.

Definitions:

Contracted Insurance Company -	Insurance Company with which SCA has a current agreement. Government payors such as Medicare and Medicaid are generally treated similarly to contracted insurance companies
Covered Services -	Services that are normally paid for by the payer (i.e. commercial insurance company or governmental payer)
DOS –	Date of Service
Non-contracted Insurance - Company	Insurance Company with which SCA does not have a current contract
Non-covered Services -	Services that are not normally paid for by the payer. Examples may include cosmetic surgery
PAS –	Patient Accounting System

Policy Statement:

The Collector or other designated teammate is responsible for reviewing accounts to go to outside collections, writing off accounts to bad debt, generating patient statements, researching claim denial appeals and ensuring the resolution of coding issues. The Collector is responsible for resolution of all account balances.

Account Resolution: Ensure unpaid accounts have been researched, analyzed, adjusted/corrected and submitted for payment to the appropriate payer and payment is received within established time frames.

Account resolution requires that the Collector must be knowledgeable of the center's ***current*** managed care agreements to ensure payments are made according to the terms of the agreement.

Procedure Steps:

A. Insurance Collections:

- Minimal account activity:
    - Account follow up must occur on accounts with debit or credit balances every 30 days at a minimum. Account follow up may occur prior to 30 days based on the outcome of the last follow up action needed.

- Follow up actions may be performed via payer portal or a phone call to the payer.
- Follow up efforts must be entered in the PAS or other workflow system with defined target dates for follow-up/expected resolution. Target/follow-up dates may not exceed 30 days.
- Reasonable efforts must be made to comply with insurance company's requests for additional information needed to process claim. Payer specific time frames must be followed.
- Though not to be considered minimal insurance collection activity, facilities have other options in attempting to obtain claim resolution, such as:
  - ✓ Facilities may contact their Regional Director of Payer Strategies and Site Engagement Partner for assistance in working with contracted payors to resolve claim disputes at an *impasse or non-responsiveness* from contracted payors. Claim data should be quantified and all communications with the payer must be documented prior to seeking assistance. Check with Payer Strategies and/or the payer website regarding the appropriate format for reporting claim disputes.
  - ✓ Facilities may confer with their state's Department of Insurance for guidance in dealing with non-responsiveness payors.
  - ✓ Facilities may inform patients of unpaid claims and request their assistance (not payment) in resolving the unpaid claim with the payor utilizing the **Patient Claim Status Notification**, see **Attachments and Links**.

B. Patient Responsibility

- Minimal account activity:
  - At least one regular statement but no more than three statements should be sent to the patient or responsible party after the balance is transferred to self-pay.
    - ❖ ***Best Practice***: If the patient does not respond to the statement(s), send to the center collection agency of choice for letter series collections (not bad debt).
  - Centers that do not use an internal letter series should send accounts to Phase II collections (bad debt) after 3 statements. If the center is partnered with a specific healthcare system, ensure that their financial policies are reviewed and adhered to.
  - If the patient does not respond to the letter series or statements, send to the facility's preferred outside collection agency for bad debt collections. Account should be written off to bad debt in the PAS at this time.

Collection Report Examples (may vary by PAS):

Reports should be generated from the PAS or other workflow system daily (weekly at a minimum) to identify accounts to be worked and/or create workflow lists.

- Memo Tickler Report from SCA Insight (dependent on PAS interface to UDM) - Lists accounts in need of follow up based on last action taken and documented in PAS
- Notes Report from PAS – Lists accounts in need of follow up based on last action taken and documented in PAS
- Collection Follow-up by Payer (or similar) from PAS – Lists accounts by payer/financial class with debit balances.
- Payer AR Aging from PAS – Provides overall view of AR balances by aging bucket
- Billing Status Report from PAS – Review to review/reconcile unbilled cases
- Transaction Information Report **from** PAS – Provides information on denials/validation codes entered for specific DOS or transaction dates if entered in the PAS.

The Collector or designated teammate is responsible for the following:

Credit Balances: Determine if credit is valid and enter plan for resolution within 3 business days from the transaction date that created the credit.

Refer to policy ***RCO_08_103: Credit Balance - Refund Management*** for detailed instructions.

Denials Management: Accounts that have been denied or requests for additional information will be researched, corrected and resubmitted for payment within 3 business days. The target date and assign to components of the collection process will be used to follow-up on all denials/other accounts and all re-submitted claims. If/when there is a request for additional patient information from the payer, the collector or designated teammate will contact the patient and request that they respond to the insurance carrier's request as soon as possible.

Self -Pay: Accounts that have transitioned from insurance to self-pay must follow a structured statement process.

Refer to policy ***RCO_08_109 Patient Statements*** for detailed instructions.

Underpayments: When the payment amount is less than the expected payment the account will be researched to determine the reason. The Collector or designated teammate will send a Notification of Payment Discrepancy Letter when resolution cannot be obtained over the telephone or will follow payer guidelines regarding submitting a reconsideration or appeal as is applicable.

External Collection Agencies: Unpaid patient accounts that are older than 45-90 days are eligible to be turned over to outside collection agencies.

Refer to policy ***RCO_08_0113 External Collection Agencies*** for detailed instruction.

BASIC RULES

1. Whenever an account is worked a complete note MUST be recorded in the Notes/Memo section in the PAS and/or workflow system.
2. Each note should be given a target date and an assigned to a teammate for subsequent follow-up.
    - Target/follow-up date may not exceed 30 days.
3. Notes should include at a minimum:
    - Phone number and payer called, name of contact at insurance company, a brief description of action plan/expected resolution and call reference number if provided.
4. Each account MUST have documented follow-up every 30 days. Accounts will be worked in order of oldest/largest dollar balance to youngest/smallest dollar balance.
5. Do not re-bill unless there has been a change in claim information (i.e. patient information or payor requirement). Note changes made to claim information in the PAS upon claim re-bill/resubmission.
6. When a claim is not on file the note/memo documentation must include the Who, What, When and Where.
    - Prior to resubmitting a claim verify that the payer is correct, ECS ID is correct if applicable and/or payer address is accurate
7. Re-billing is NOT a collection tool.
8. Do not mass re-file unless there is an identified payor issue or systems issue for a given date and the reason is documented.

WHAT DO WE NEED TO RESOLVE ACCOUNTS?

1. Consistent use of all available tools.
2. Consistent use of Denial Codes and Validation Codes clearly explained in the Notes/Memosection in the PAS.
3. Understanding of procedures necessary to turn accounts to outside collection agencies.
4. Clear definition of accounts that must be written off (i.e. Non-Covered, No Pre-Cert, etc.)
5. Ability to spot trends (ex. Why are so many claims from Aetna being rejected for code 12345?)
6. Offer Care Credit as a payment option for balances >$300.00. Use for time of service payments and after insurance payment option if the center participates.

Enforcement:

Any teammate found to have violated this policy may be subject to disciplinary action, up to and including termination of employment.

Business associates found to have violated this policy may be subject to financial penalties, up to and including termination of contract.

These policies, procedures, and forms are compiled based on both legal and regulatory requirements as well as industry standard best practices. Persons are expected to use established practices and sound judgment in making decisions.

SCA policies and procedures are confidential proprietary information that should not be disclosed to individuals outside SCA. All confidential or proprietary information should be protected against theft, loss, and unauthorized disclosure.

Review and Update:

This policy is to be reviewed annually to determine if the policy complies with current regulations and SCA practices. In the event that significant related changes occur, the policy will be reviewed and updated as needed.

Contact Information:

If you have questions or concerns regarding this policy, please click on “Approval Details” (on the top right) and email the “Approved By” person. Include the policy name and number in your email. If you cannot reach the policy approver or if you need further assistance, please email regcomp@scasurgery.com.

Prior to MCN Healthcare

Reviews and Approvals:

Reviewed by	Date
Matthew Warren	06/09/2010

Approved by	Date

SCA Internal Use
Only ID: 14080