Driscoll Health System

Chapter:	Subchapter:	Effective Date:
Patient and Financial Services	Patient Financial Services	01/01/2015
Title: Billing and Collections Policy		

☐ Driscoll Health System (DHS) ☒ Department: PFS ☐ Driscoll Health Plan (DHP)
☐ Driscoll Children's Hospital (DCH) ☐ Physician Groups

PURPOSE:
To outline the billing and collection process for DCH that is consistent with the hospital mission, vision, and values.

PERSONS AFFECTED:
Patient Financial Services (PFS), Outsourcing Vendor, Patient Access

DEFINITIONS:
Collections: A measured approach to collecting a debt that is owed by an insurance company or by the guarantor that was incurred at DCH.
Insurance Payer Collections: An amount that is due from the insurance company who insures the patient that was serviced at DCH.
Self-Pay Collections: The remaining debt is only due from the guarantor after any other payers listed on the account have satisfied their portions.

POLICY:
DCH will bill for services in a timely and accurate basis and have a systematic approach to collections that consists of statements, follow-up calls and outsourcing accounts the hospital deems necessary. DCH also reserves the right to report to the credit bureau when needed.

PROCEDURE:
1. Billing:
   Although dependent on information and communication from patients and payers, DCH will provide sufficient intake and follow-up service to ensure that patients receive accurate account and billing information and have the opportunity to make payment and/or apply for financial assistance. Under no circumstance will DCH engage in any extraordinary collection actions before making a reasonable attempt to determine if a patient is eligible for assistance under the hospital's financial assistance policy. The billing process will be assisted by the following guidelines:
   a. For all insured patients, DCH will bill all insurance payers as a courtesy to the patient in a timely manner.
      - Once all charges are posted and coding has completed their review then the claim drops over to the Billing Department.
      - Claims are scrubbed against edit rules in EPIC.
      - Any issues/errors are corrected and run through the scrubber again.
      - Claims are bridged into Epremis (billing clearinghouse).
      - Claims are scrubbed against payer edits in Epremis.

- Claims are released to payers electronically or printed to paper when applicable.
- Any claim that does not get accepted by the payer comes back on a 277 report from Epremis.
- Rejected claims on the 277 report are worked, corrected, and released again.

b. If a claim is denied (or is not processed) by a payer due to a DCH error, DCH will not bill the patient for any amount in excess of that for which the patient would have been liable had the payer paid the claim.
c. If a claim is denied (or is not processed) by a payer due to factors outside of DCH's control, hospital staff will follow up with the payer and patient as appropriate to facilitate the resolution of the claim. If resolution of the claim does not occur after reasonable follow-up efforts, DCH may bill the patient or take other actions consistent with current industry standards.
d. After claims are processed by payers, DCH will bill the patient's in a timely manner for their respective liability amounts as determined by their payers.
e. All uninsured patients will be billed directly in a timely manner through the method of statements. All patients may request an itemized statement for their accounts at any time.
   - DCH will approve payment arrangements for patients on a case by case basis. DCH is not required to accept patient-initiated payment arrangements and may refer accounts for collections if the patient is unwilling to make acceptable payment arrangements or has defaulted on a DCH approved payment plan.
f. All billed patients will have the opportunity to contact DCH regarding financial assistance for their accounts. Financial assistance may include charity care, payment arrangements, medical assistance, or other applicable programs.

2. Insurance Payer Collections:
   a. DCH will follow-up on insurance payer accounts in various ways. Examples include: resolving system generated reminders (ticklers created based on dollar amount and age), working payer remits, working collector work lists and resolving remit codes generated from denials.
   b. The collection cycle will vary depending upon the financial classification (insurance payer). Insurance payer accounts will be classified as the following:
      - Commercial
      - Medicare
      - TX Medicaid/PCCM
      - Worker's Compensation
      - Tricare
      - Blue Cross Blue Shield
      - Commercial Managed Care
      - Medicaid Managed Care
      - CSHCN
   c. DCH will take the collection effort on insurance accounts (i.e. all payers excluding self-pay) based on the following guidelines:
      - All insurance payer accounts are worked initially at thirty (30) days from billed date and every two (2) weeks thereafter.
      - These guidelines apply to all Insurance Payer collection accounts (final billed and interim billed) including denials, appeals, follow-up, etc.
   d. DCH will ensure adequate follow-up is occurring, by monthly reviews by the PFS Supervisors and will be conducted within the following time frames:
      - PFS Supervisor will review ten (10) accounts per collector > ninety (90) days from bill date each month.

- The above criteria for PFS Specialists and Supervisors apply to final billed and interim billed insurance payer accounts receivable. For follow up purposes, elapsed time will age from bill date.

3. All patients
   a. PFS will work all accounts with a high propensity to pay, which is determined by our vendor that scored each guarantor by their credit and payment history. The PFS Specialist is expected to answer calls from guarantors with any billing questions. The PFS Supervisor will monitor in-bound and out-bound calls monthly and adjust workloads accordingly.
   b. After the appropriate actions listed below are taken, self-pay accounts (total balance of account is in the self-pay "bucket") that do not have payment arrangements and that are forty (40) days old (from Work Queue (WQ) placement) will be placed with our extended business office to send out statements/letters and work with families to set up payment arrangements.
   c. DCH provides financial assistance for applicable patients that are consistent with the DCH Mission, Vision and Values and in accordance with Texas law and the office of the Texas Attorney General.
   d. Financial assistance is offered to patients on the dunning statements and when patients or guarantors call inquiring about their bill. A copy of the Financial Assistance Policy, Financial Assistance Application or Plain Language Summary is located at: http://review.driscollchildrens.org/patient-services/charity-care
   e. Patients will have a total of 120 days from the first billing statement received after discharge from the hospital to request a financial assistance application before collection efforts including placement with an outside collection agency may occur with reporting to their credit file. The patient will have an additional 120 days to submit a completed application for final financial assistance determination. Any collection efforts will cease if the assistance application is received at any time within the 240 day period and any requested additional application information completed prior to the end of the application period which is a total of 240 days from the first billing statement after patient's discharge. Financial Assistance applications will not be accepted nor processed once all notification and application requirements have been met and 240 days from the first billing statement after the patient discharge date has expired.
   f. In the event of an incomplete financial application form and no response to requests by phone and/or letter, a final notice will be sent identifying the information needed to make a final determination of financial assistance eligibility. A copy of the financial assistance summary policy with any extra collection actions to be taken will be included in the final notice allowing no less than 30 days for the patient to respond with the required information. If additional information is received or there is adequate information to make a determination in the patient record, all collection efforts will cease until determination is finalized. If information or payment is not received and there is not adequate information to make a determination in the patient record and 120 days has passed from the first patient statement after discharge, normal collection efforts will resume including referring to an outside collection agency for additional collection efforts and reporting to their credit file. If at any time prior to 240 days from the first patient statement, a completed application or requested information is received, all collection efforts will cease and the financial application processed for final determination. DCH will make every attempt to reverse any collection actions (ECAs) initated should the final determination indicate the patient is eligible for financial assistance.
   g. DCH reserves the right to report to a credit bureau, after making reasonable efforts to determine if a patient qualifies for financial assistance.

INTERNAL CROSS-REFERENCES:
Not Applicable

REFERENCES:
Emergency Medical Treatment and Active Labor Act