



INSURANCE BILLING & COLLECTIONS PROCEDURES

- I. PURPOSE:** To establish logical, consistent methods of billing and collections follow-up for insurance balances to ensure that all staff members possess a good understanding of how to appropriately and effectively work these accounts. To ensure that all actions taken on every account are consistent, compliant, legal and ethical.
- II. POLICY:** It is the policy of Rice Memorial Hospital to implement billing and collections procedures that will equitably and proficiently facilitate the collection of insurance balances. Employees of Rice Memorial Hospital are strictly forbidden from displaying behavior that is abusive, harassing, oppressive, false, deceptive or misleading to the payer representative, patient, or any other customer.
- III. RESPONSIBILITY:** Business Office Staff
- IV. INSURANCE BILLING:**
- a. Confirm benefits on all inpatients. Record benefit information in patient account notes. Send to care management for certification if needed.
 - b. Billing Timeframes:
 - i. Clean claims that do not require any edits or additional information should be billed (batched, accepted, and sent to clearinghouse) to all known insurance companies/ health plans within five calendar days of patient discharge (Epic minimum days is currently set at five).
 - ii. Claims that require edits or additional information prior to billing should be resolved within 3 days of being posted to a work queue. For initial billing, this means that claims with edits should be billed within 8 calendar days of patient discharge.
 1. Claims that require charge review are placed in the responsible department's charge review work queue. Biller must follow-up with department via email if no action has been taken within 2 calendar days of claim being placed on the work queue (as all departments must work these work queues daily).
 2. Claims with missing codes (procedure, diagnosis, modifier, etc.) are placed in the responsible coder's claim edit work queue. Coder is to place an account note on the account with the status of the claim. Biller must follow-up with coder via email if no action has been taken within 3 calendar days of claim being placed on the work queue (as all departments must work these work queues daily).
 3. Claims that contain physician or records delinquencies are to be placed in the appropriate physician's in-basket for completion. After the ten-day timeframe has passed (since the account was placed in the physician in-basket), Medical Records or CDI staff member should follow-up with the physician in order to ensure delinquencies are completed.
 4. Other claim edit scenarios not mentioned should follow similar protocol and time frames.

- iii. Claims that are held in the clearinghouse should be resolved within one day of clearinghouse claim edits posting to the claim.
- iv. Claims that are submitted to the payer through the clearinghouse but are initially rejected by the payer (prior to being processed) should be resolved and re-submitted to the payer [via the clearinghouse] within three calendar days.
- c. The claim transmitted to an insurance company **must** be an exact duplicate to that which is in the Patient Accounting system in terms of coding and dollars billed.
 - i. All claims data in the Patient Accounting system must match the claims data in the Claims Management system.
 - ii. All claims sent to the insurance company **must** be generated by the Patient Accounting system and NOT by the Claims Management System. The only time it may be appropriate to initiate a billing from the Claims Management system is if the payer did not receive the original bill and other **exact duplicate** of the original is being sent to **exactly** the same payer. In this instance, staff are required to document that this action was taken within patient account notes in the Patient Accounting system to ensure it is clear when re-billed occurred. The other exception to not billing out of the Patient Accounting system would be to send a canceled or adjusted claim through the Claims Management system when necessary.
- d. Billing staff is not authorized to make changes to HCPC, CPT, diagnosis or procedure codes. Modifiers should be reviewed and approved by coding prior to being changed unless the modifier is obsolete to coding and therefore billing staff have the approval to add.
 - i. Only the documentation found in the patient's medical record should lead coders to the diagnosis(es) relevant to a claim. Given the many physiological elements or even organ systems involved in most conditions, it is commonly the case that a patient's clinical condition legitimately may be described in a number of different ways, at a number of different levels, and by a number of different (and all reasonable) code selections. The current ICD-10 code(s) and other coding systems reflect this complexity in their tightly inter-related hierarchical classifications of disease.
- e. Combining Accounts
 - i. A coder must review accounts that fall under the Medicare 72 hour window when outpatient services are non-diagnostic. All inpatient readmissions on the same day, or any outpatient accounts on the same day that reimburse via EAPG methodology, will be reviewed by coding before the accounts are combined.
 - ii. Insurance Company Requests for additional documentation and/or claim: Ensure that current financial class on the account is the same as the insurance company who is requesting the documentation. (e.g. BCBS calls for records but the current financial class is Self Pay. Change current financial class to BCBS)
 - 1. Encounter pending provider information (MR request, etc.): Billing staff member worked the encounter and worked together with other departments as necessary to send requested information to the payer within seven days of receiving notice from the payer. Biller then followed-up with payer in 15 days to confirm necessary information was received. Unless time frame exceptions by payer are approved by direct supervisor.
 - a. If HIS department is involved, biller or coder should contact the department for the information requested and place a note on the account for requested information to HIS. A tickler should be set to follow-up with

the department in 3 business days if the request remains unfulfilled.
Follow-up with payer should occur 14 days after records have been sent.

- i. Please see Medical Record Request – Billing and Medical Record Request - Appeals
2. Encounter pending patient information (COB request, accident information, etc.): Billing staff member attempted to contact the patient to help facilitate this request within seven days of receiving notice from the payer. If the patient is not reached by phone, the biller should place two additional attempts to contact the patient. Smart text letter should be sent out and a phone call placed 14 days after letter is sent.
 - a. If patient/guarantor is contacted: Biller should followed-up with payer in 14 days to confirm necessary information was received from the patient.
 - b. If patient/guarantor is not contacted: After three contact attempts have been made, balance may be transferred to Self Pay and billed to patient. One smart text letter sent and two follow up calls placed.
 - i. Please see RMH Self Pay B&C Procedures

V. POSTING (Payments, Remittance, Correspondence)

- a. All payment, remittance advice, and other correspondence received (from any payer, patient, or guarantor) are posted within one business day during the business week and immediately on Monday if payments received during the weekend.
- b. All balances are transferred to the Next Responsible Party within 24 hours of payment or remittance receipt [or when approved by leadership]
 - i. All secondary claims are billed within 24 hours of posting the primary payment or remittance)
- c. Identified refunds to insurance must be made within 30 days after the date of receipt of the remittance advice if there is not a review of the account for a denial or appeal (refer to the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 30, Section 50.13 for additional information)

VI. INSURANCE FOLLOW-UP

- a. 1st Position/Primary: The primary payer should always be in the first position. If insurance coverage is no longer active for a certain payer, the termination date should be entered within the coverage record and the coverage removed from the account being billed, and the new primary insurance should be added and billed.
- b. Collection Activity Guidelines:
 - i. Primary Payer: Encounter has note indicating it was worked within 30 days of initial billed date
 1. When no payer response has been received within 30 days of billed date, Claim Status should be checked and the Claim Number (ICN#), payer representative name, claim status, and other important information for future follow-up is documented in a patient account note
 - ii. Primary or Secondary Payer: Encounter has note indicating it was subsequently worked within 30 days of each follow-up attempt [denial & appeal-related follow-up attempts excluded]

- iii. All denials should be appealed within seven days of receipt from the payer. If this cannot be accomplished due to additional department involvement, clear documentation of steps taken must be noted in the account.
- iv. Action should be taken and documented in a patient account note by staff members every time the encounter is worked
- v. All collection actions taken on the encounter are clearly and consistently documented in Epic

VII. DOCUMENTATION

- a. **All** action taken on an account and/or claim **must** be documented in the patient notes in the patient accounting system.
 - i. Forms of bad documentation:
 - 1. PER RYCAN EOB BALANCE IS PR
 - 2. C/A BALANCE
 - 3. PRIMARY PAID MORE THAN SECONDARY ALLOWS
- b. When requesting refunds and recoupment place a note on the patient's account for:
 - i. Date refund request was sent to Accounts Payable
 - ii. Amount of Refund
 - iii. Who refund is to
 - iv. Why the refund needs to be sent
- c. Detailed notes taken during a conversation or in regards to action that should be taken on the account must be entered in the patient's record in the patient accounting system concurrently with the conversation. If this is not possible all paper notes should be transcribed into the patient's record on the patient accounting system. Notes must include but are not limited to:
 - i. Name of person being conversed with
 - ii. Association of the person in relation to the account (ex. Parent, insurance company, care taker)
 - iii. Number used to contact the person in the conversation (if Rice initiated contact)
 - iv. Claim status
 - v. Claim reference number
 - vi. What next steps or action needs to occur, and what the follow-up timeframe should be
 - 1. A tickler should be set that is consistent with this follow-up timeframe

VIII. CREDITING OF CHARGES

- a. Charges should never be credited when a balance is being reduced for public relation or charity care reasons.
- b. Reasons for Crediting Charges:
 - i. Crediting of charges should occur when crediting an incorrect charge and replacing it with a valid charge.
 - ii. Crediting of charges should occur when the service was not provided and/or not documented.
- c. Charge Crediting Process:
 - i. Claims/charges should be transferred to the analyst to review, with patient account notes on why specific charges should be credited.
 - ii. Analyst will review the claims/charges in question.

1. If analyst agrees with changes: analyst will post changes to the encounter
2. If analyst disagrees with changes: analyst will deny request, place patient account notes explaining why, and transfer the account back to the requestor to be worked
3. If analyst decision requires additional information: analyst will contact the requestor to obtain additional necessary information required to make the correct decision

IX. ADJUSTING BALANCES

- a. Administrative Adjustments occur to reduce negative public relations and are approved by the department director and director of revenue cycle.
- b. Contractual Adjustments are created for the difference between the charged amount and the allowed amount per **contracted agreement** between Rice Memorial Hospital and payer. Approved by the Analyst.
- c. All other adjustment requests are sent to the adjustment work queue and approved by analysts, supervisor, or director
 - i. Adjustments less than \$5,000: Approved by the assigned responsible user
 - ii. Adjustments greater than \$5,000: Reviewed by the assigned responsible user, and submitted to the CFO for approval

X. NON-PAYMENT BY INSURANCE Refer to RMH Self Pay B&C Procedures

- a. When a bill remains unpaid and work is being done with the insurance company to obtain payment, patients should be informed of the progress every 30 days.
- b. When insurance denies with the reason of needing additional information from the patient, the patient must be notified. An attempt should be made to contact the patient by phone within seven days of receiving a patient information request from the payer, and a letter should be sent to the patient. If the patient was not reached, the biller should place two additional attempts to contact the patient by phone. (See RMH Self Pay B&C Procedures for more information).
- c. Patient Responsibility **denials** must be thoroughly investigated to ensure that the patient is in fact responsible for the amount before assigning to the patient/changing amount to self pay.
- d. Coverage denials: Verify that all subscriber information originally submitted on the claim was accurate before changing to patient responsibility (See RMH Self Pay B&C Procedures for more information.)

XI. APPEALS

- a. The third party's appeal process should be considered and followed when submitting a claim for appeal
- b. When submitting an appeal, the following steps should be taken to make a convincing and logical appeal to the payer.
 - i. State why the claim was denied in the comment section of the appeals form.
 - ii. Submit a valid, detailed argument as to why the appeal should be paid and any new evidence to support payment that is being included in the appeal in the comments section of the form. Assistance with the development of detailed written response from a department director related to the services denied may be requested.
 - iii. Reference documentation in the argument and include document pointers such as, "see attachment A"
 - iv. Include copies of the reference materials with the appeal for payment.
 - v. Include a list or index of reference/attachment material in the appeals documentation.

- vi. Retain a copy of the appeal with ALL attached supporting documentation within the appeal denial management module.
- c. Appeal follow-up timeframes:
 - i. Account was worked and biller appealed denied claim within 7 days of receipt
 - ii. Appealed claim was followed-up on every 30 days after submission
 - iii. Denied encounter is escalated to supervisor if appeal letter is necessary.
 - 1. After evaluation, an outside vendor may be utilized for claim resolution.