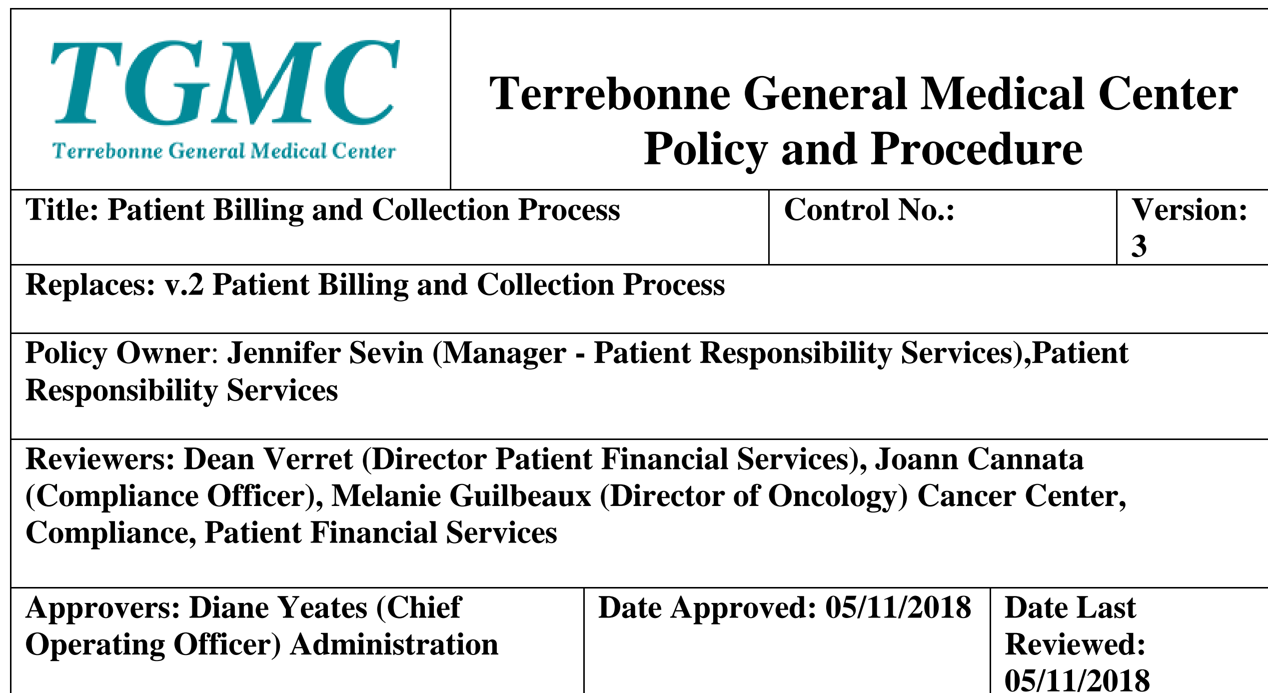

| TGMC Terrebonne General Medical Center | Terrebonne General Medical Center Policy and Procedure | |
|---|---|---|
| **Title: Patient Billing and Collection Process** | **Control No.:** | **Version: 3** |
| **Replaces: v.2 Patient Billing and Collection Process** | | |
| **Policy Owner: Jennifer Sevin (Manager - Patient Responsibility Services),Patient Responsibility Services** | | |
| **Reviewers: Dean Verret (Director Patient Financial Services), Joann Cannata (Compliance Officer), Melanie Guilbeaux (Director of Oncology) Cancer Center, Compliance, Patient Financial Services** | | |
| **Approvers: Diane Yeates (Chief Operating Officer) Administration** | **Date Approved: 05/11/2018** | **Date Last Reviewed: 05/11/2018** |

## Purpose:

This policy sets forth guidelines for consistent billing and collection processes on all Guarantor balances.

## Scope:

This policy applies to all Guarantors of patients that have an outstanding hospital patient balance at Terrebonne General Medical Center.

## Policy/Procedure:

TGMC is committed to following a consistent approach to notify all Guarantors of financial responsibility and provide 210 days to resolve account balances before transferring accounts to bad debt. Collection efforts may include statements, telephone calls, letters, online bill pay and access to a customer service representative which can provide assistance regarding billing inquiries.

A. Statements
   a. Statements are generated after determination of patient responsibility.
   b. A minimum of 7 patient statements are sent based on a 30 day cycle.
   c. It is the patients' responsibility to inform the hospital of any active insurance coverage(s) applicable to their visit within 210 days from the first statement date. If active insurance coverage is discovered after the timely filing period, the balance will remain patient responsibility.

   d. Patients will not be sent a statement for any balances not previously billed to the patient within 12 months of determination of patient responsibility.

B. Additional collection activity process
   a. Accounts may be eligible for outbound collection calls which may either be made in house or by an Early Out Collection vendor responsible for making outbound collection calls.
   b. Accounts will be placed with an Early Out Collection Vendor from the first statement date.
   c. Accounts remain with Early Out Collection Vendor until the outstanding balances reaches 180 days from the first statement date and 6 statements have been sent.

C. Bad debt determination and transfer process
   a. Accounts qualify for bad debt placement when the account balance is outstanding for a minimum of 210 days from the first statement date.
   b. Bad debt accounts may be placed with one of two primary collection agencies.
   c. Collection attempts are made by the primary agency for a minimum of 60-90 days from the date of placement.
   d. When normal collection attempts fail, the collection agencies can recommend legal action. Legal action may include phone calls and letters in order to effect collections. In addition, after obtaining prior approval from TGMC leadership, the collection agencies' legal counsel can seek judgments and garnishment of wages for effective collection of a bad debt.
   e. TGMC collection agencies may report patients to the various credit reporting agencies.
   f. Unresolved accounts or accounts not on an active payment arrangement may be closed and returned to TGMC to be tagged as uncollectible bad debt in the patient accounting system.

D. Uninsured Discount
   a. For patients who are uninsured, the financial assistance discount is applied to gross charges for the eligible services after first deducting the uninsured discount on technical charges. The Uninsured discount represents the average payor yield by reviewing Medicare and commercial actual and expected Payments (including the patient portion) over the prior twelve month period. In no event are gross charges billed to a patient approved for Financial Assistance without a corresponding discount.

**Enforcement and Exceptions:**

A. Early placement to an outside collection agency may be determined by a representative regardless of age for the following reasons:
    a. Mail Returns/Skips
    b. Deceased/Successions
        i. In compliance with Medicare guidelines, TGMC will cease billing processes once formal notification of the death of a Guarantor is received.
        ii. Accounts with outstanding balances may be referred to an outside agency for further research to determine if a claim against the estate should be filed.
B. Some accounts are not sent to collection agencies based on presumptive financial assistance eligibility.
    a. Persons may be considered presumptive eligible under the following circumstances:
        i. Medicaid recipient with financial responsibility for medically necessary services;
        ii. Persons who are mentally or physically incapable of providing documentation and have no known family or other assistance;
        iii. Deceased person with no apparent estate or spouse financially able to satisfy the debt;
        iv. Persons whose identity cannot be established;
        v. Persons who are incarcerated;
        vi. Transient, homeless persons.

C. The director, managers and supervisors of Patient Financial Services are responsible to communicate, monitor and measure compliance of the above documented policies and procedures.
D. Requests for exception to this policy must be submitted to the Chief Operating Officer, or designee, and describe the reasons for requesting the exception.
E. Prior to the approval of any exception request, policy requirements will continue to be abided by

**Definitions:**

A. <u>Early Out Collection Vendor:</u> Outside agency responsible for the outsourcing of collection attempts prior to being considered bad debt.
B. <u>Guarantor:</u> The party responsible for payment of charges not covered by insurance or all charges when the patient does not have insurance coverage (Self-Pay/Private-pay patient).
C. <u>Reasonable Collection Efforts:</u> A minimum of 5 patient statements are sent based on a 30 day cycle; patients are provided 150 days to resolve account balances or apply for financial assistance before transferring accounts to bad

debt; and, patients are offered the financial assistance plain language summary during the registration process.

**Equipment:**
N/A

**References:**

Financial Assistance Program Policy
Self-Pay Reductions Policy
Payment Plans for Self Pay Balances