CC015 PFS Patient and Third Party Billing Collections

ISSUED DATE: Not Set	**APPROVED DATE:** 02/22/2021
PREPARED BY: Dawn Bunch (Billing Supervisor)	
APPROVED BY: Tammy Hoke (Director of Patient Accounts)	

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I. PURPOSE: To establish and communicate the patient and 3rd party billing policy of Wayne Healthcare

II. POLICY: To provide billing and collections a process for payment on patient accounts.

III. GUIDELINES:

1. The payment of charges for supplies and /or services rendered to a patient by Wayne HealthCare is the responsibility of the patient or responsible party of the patient.

2. Payments for supplies and /or services rendered by Wayne Healthcare are due in full at the time they are rendered.

3. Third party payers (Blue Cross, Commercial Companies, Medicare, Medicaid, and Bureau of Worker's Compensation, etc.) may be accepted as the payer of a patient's account. However this does not relieve the patient from full payment of any and all charges for supplies and/or services rendered by Wayne Healthcare.

4. Cashiers, Pre-Registration, and/or Registration will make every effort to collect on patient accounts in full or any portion of a patient account (co-pay, deductible, out of pocket expenses), that is not covered by an acceptable third party payer at the time the supplies and/or services are rendered.

5. Patient Financial Services will provide the patient with information regarding methods of payment for hospital services, such as arranging an agreeable payment schedule based on the payment guidelines, public assistance, uncompensated services etc.
   a. The Wayne Healthcare Patient Billing and Financial Counseling pamphlet will be used as a guideline for payment arrangements. (See attached example A)
   b. Wayne Healthcare Financial Assistance policy will be followed for the Hospital Care Assurance Program (HCAP) and Hospital Charity program.
   c. Documentation will be noted in the patient account in regards to financial assistance findings.

6. Attempts will be made to see all self-pay patients while in-house. Firstsource/Med Assist and/or the registration clerk will prescreen the patient for possible Medicaid coverage at time of registration. Registration will notify Firstsource/Med Assist for presumptive Medicaid coverage.

7. Central Scheduling will provide the patients with the admission/deposit requirements. The Wayne Healthcare Patient Billing and Financial Counseling pamphlet will be used as a guideline for admission/deposit requirements. (see attached example A)

IV. BILLING OF PATIENT PAY ACCOUNTS

Billing of patient pay accounts, which are not paid at the time of service, will be as follows:

1. The patient or guarantor will be billed for the account balance.

2. Additional billings on unpaid accounts will follow the 501r guidelines established with the third party billing company and at twenty-eight (28) day intervals up to 120 days the patient and/or guarantor will be issued a monthly statement for the balance due, as well as 3 phone calls within the 120 days:

   - DAY 1- First Notice with Detail Sent
   - DAY 15- Calls Begin (1 of 3)
   - DAY 30- Reminder Notice Sent
   - DAY 35- Calls Continue (2 of 3)
   - DAY 60- Past Due Notice Sent
   - DAY 76- Calls Finish (3 of 3)
   - DAY 90- Final Demand Notice Sent
   - DAY 120- CLOSE

3. When an account remains unpaid at the conclusion of the statement, phone calls and collection letter run, the third party statement company will return the account to Wayne Healthcare for bad debt processing.

4. The guidelines for monthly payment arrangements can be found in the Wayne Healthcare Patient Billing and Financial Counseling pamphlet under the Payment Plan Guidelines. (see attached example A)

5. The patient will receive a monthly statement and/or payment book indicating their payment is due. If the patient account that is on a payment plan becomes delinquent and the patient/guarantor has not made a payment in 45 days the balance will be in arrearage.
   Terms that are not agreed upon or to the payment plan policy will be eligible for bad debt processing.

6. Accounts that are requested to be joined will follow the payment plan guidelines (see attached A). Accounts that do not meet the payment plan guidelines will not be joined unless approved by the Supervisor. The collector can refuse joining due to poor and inconsistent payments, or the account balance is greater than the payment plan guidelines. If the account is in arrearage, step 3 is to be followed.

7. If an account has mail returned for bad address, the following action is taken:
   a. Check for current address on more current patient accounts.
   b. Use available directories and contacts to check current address
   c. Set up new address for statements.
   d. No new address, refer to collection agency using the bad debt policy CC001.

8. Bad debt patient accounts will be set with cycle code (1) and collect code (B) for collection agency transfers. Bad debt and Repeat offenders are determined by:
   a. Bad debt history
   b. No response to statements, letters or phone calls on accounts.

c. Low and inconsistent payments, not paying to terms, not paying monthly, not paying.
d. Fraudulent or uncooperative information given during registration.
e. Threats of bankruptcy

V. BILLING OF INSURANCE FOR PATIENT ACCOUNTS:

The billing of third party payers will be as follows:

1. Accounts with acceptable third party coverage will be billed to the proper carrier upon coding completion.

2. Balances remaining after receipt of payment from a third party payer or rejection/denial of benefits from a third party payer will be sent to the patient/guarantor to be paid in accordance with the procedure of billing patient pay accounts.

3. Accounts that have been actively worked through Patient Financial Services Department can be billed to the patient up to eighteen (18) months after the last date the account was actively worked.

Accounts that are older than eighteen (18) months will follow policy and procedure CC031, write offs. Worker's Compensation claims can be billed after they have been denied. The time frame does not apply to Worker's Compensation claims.

VI. Minimum payments on accounts are $25.00 unless approved by upper management for a predetermined time frame and amount.

ISSUE DATE:	REVIEW:	REVISION:	ISSUED BY:	APPROVED BY
2000	2001			
	2002			
	2003			
	2004			
	2009		Carolyn Brant	
	2012		Carolyn.Brant	
	Jan 14 2013		Carolyn Brant	
	December 2013		Carolyn Brant	
	April 2014		Peg Emrick	
	February 2016		Carolyn Brant	
	September 25, 2019		Dawn Bunch	
	October, 2020		Dawn Bunch	