| PHYSICIANS AMBULATORY SURGERY CENTER | | |
|---|---|---|
| **DEPOSITS & HANDLING CASH & POSTING PAYMENTS & COLLECTIONS** | **COLLECTIONS** | **Page 1 of 4** |
| **POLICY: BO-36** | **EFFECTIVE DATE:** | **APPROVED BY:** |
| **DATE REVIEWED:** | **DATE REVISED: 6-23-16** | |

**PURPOSE**
To describe parameters for appropriate collections activity

**POLICY**
1. Successful collections depends on a myriad of factors all being accurately completed. Patient scheduling, registration, insurance verification, financial counseling, insurance billing and follow up and patient billing and follow up all impact the effectiveness of collections activities. All business office staff member plays a critical part in meeting our collections goals.

2. Collection activities should be governed by the following standards:
    a. Every account with an outstanding balance should be followed up (and the follow up documented in the computer system) at least every 30 days.
    b. Accounts should be worked by priority of age and value.
    c. Accounts receivable days should be maintained at less than 55 days in receivable on average. (To calculate days in A/R take the last 3 months net revenue, divide by the total calendar days in that time to get the average net revenue per day, then take the total net A/R for the current month end and divide by the average net revenue per day.)
    d. Accounts receivable over 120 days should be no more than 10% of the total A/R balance.
    e. Fair Debt Collection Practices and professionalism should be observed in all collection communications. (See Form 1)
    f. Generally, one full time collector can manage approximately 1,000 accounts per month.

**PROCEDURES**
***General***
1. Print reminder notes from the computer system for the day. Prioritize and perform the appropriate action whether that is a call to a patient or insurance company, sending a statement or letter to the patient, or re-filing insurance (correcting information as needed). Other possible actions include placing the account on the Bad Debt Write Off list, performing a small balance write off (if the account is less than $10), or placing the account on the Collection Agency Turnover list for the business office coordinator/ administrator to review.

2. Follow up on the previous day's activities to assure faxes were received, telephone calls were returned, etc.

3. Review list of accounts receivable by payer, so that more than one outstanding insurance balance can be worked during one contact.

4. All actions taken should be documented in the computer system. The account should not be considered "worked" unless some action that will move the account toward resolution has taken place.

5. Each contact should be a new memo that includes the date, the person with whom you spoke, the results of the discussion, a future follow up date dictated by the resolution achieved, and your initials. Abbreviations should be used but only those agreed upon and documented by the business office coordinator.

***Insurance***

1. If the insurance company representative states that the claim has been paid but the check has not yet been received, verify the mailing address and tax identification number, obtain the date of the check, the check number and amount. The payment may have been posted in error to another account.

2. The insurance collections process should begin at 35 days after the claim was filed. The collector should place a call to the insurance company to determine the status of the claim. If the claim is in process, ask for an estimated payment date and enter a follow up note for that date in the tickler system.

3. If the claim has not been received, ask if it can be faxed. If you fax a claim, follow up with a telephone call to verify it was received. Again, enter a follow up note in the tickler system.

4. If the claim is in review, determine what information is required to satisfy the review. If it is physician notes or any other item that you can obtain from the patient's chart, fax the information to the claim reviewer and ask for an estimate of when payment will be made.

5. If the claim has been denied, ask why. If it is a documentation problem, work with the coder or whoever can assist to get the claim re-filed and paid.

6. If the claim is denied for timely filing, verify this is valid in our contract with the payer. If so, add it to the list of accounts to be written off for the business office coordinator to review.

7. Medicare or any other claims that are filed electronically should be reviewed at 20 days after the claim was filed.

8. Do not hesitate to contact the plan's Provider Representative if you believe the claim processing is being delayed without reason.

9. Diligent follow up is critical to avoid claims denied due to filing after the carrier's established timely filing window.

10. Finally, enlist the patient's assistance in getting their claim processed. We file the claim with their insurance company as a service to them, however, our relationship and contract is with the patient, not the insurer. Patient calls to their insurance company can be very effective in getting a delayed claim paid.

***Patient Collections/Statements/Dunning Letters***

1. Patient statements should have standard dunning messages based on the age and status of the claim. Some possible options, depending on how your computer system ages the accounts, how it determines the need for a statement and how it handles patient vs. insurance balances are:
    a. 30 Days Old – We have filed your insurance claim for you.
    b. 60 Days Old – Your insurance has not paid your claim. Please contact your insurance carrier.
    c. 90 Days Old -- Your insurance has still not paid. Please contact our billing office to discuss payment of your claim.
    d. Over 90 Days Old – For claims more than 90 days old, begin sending one of the standard dunning letters as appropriate to the situation. See the following sample dunning letters that may be used. Note: Confidentiality must be observed when sending dunning letters. Assure that only the name and address show through if window envelopes are used. The envelope must be sealed.
    e. Over 120 Days Old – All accounts over 120 days old should be referred to the business office coordinator for review and possible turnover to a collections agency. Exceptions to this action include Medicare/Medicaid, CHAMPUS, Worker's Compensation and some HMO accounts.

2. Per Florida regulations an initial post-treatment statement will be sent seven (7) days after the DOS.
    a. This statement will prominently display the Center's patient liaison name and telephone number.
    b. If the patient requests their medical record to verify the charges, the Center must send the medical record to the patient within 10 days from the request.
    c. If the patient has any questions regarding their statement or bill, the Center is required to respond within seven (7) days after the date a question is received.

3. Subsequent patient statements should be sent at least monthly, or upon the various "triggers" your computer system may use.

***Insufficient Funds/Bankruptcy/Litigation/Caveats***

1. When a patient's check is returned from the bank for insufficient funds, the patient should be contacted immediately. Verify with your bank that they attempted to clear the check twice. When you call the patient, offer them the opportunity to clear the past due amount immediately by credit card payment, which can be taken over the telephone, by money order (set a date for receipt and follow up), by cashier's check or by bringing cash to the Center.

2. Bankruptcy notices require immediate attention. Prompt filing with the bankruptcy court is very important. Do not continue to send the patient statements or dunning letters while the bankruptcy is being processed.

3. Account balances that become part of litigation can be particularly difficult to collect in a timely manner. Patients are unlikely to want to pay on these claims until the case is settled. A letter of protection or lien may be obtained from the patient's attorney. Continue to follow up with the attorney monthly.

4. A caveat may be filed in your county probate court for patient balances that remain after you have been notified that the patient is deceased. Both the business office coordinator and the administrator should approve this action before it is taken. A form for your state may be obtained from the State Probate Office. If the caveat is returned stating that estate benefits have been exhausted, the account should be written off to bad debt.

***Collection Agency Referrals***

1. Before an account is put on the collection agency list, which must be reviewed and approved by both the business office coordinator and Center administrator, the following should occur:
   a. Statements should have been sent at least monthly;
   b. Two telephone contact attempts should have been made and documented;
   c. Three dunning letters, including a final notice that the account will be placed with a collection agency in ten days if payment is not received.
   d. Discovery that a patient gave false information, has moved with no forwarding address and cannot be contacted through employment or relatives, has written checks on a closed account, has not repaid an NSF check within 10 days, or has kept a payment made by the insurance company are all items that may trigger referral to a collection agency.
   e. Collection agency accounts should continue to be monitored every 30 days until it collected or it is evident that further collection attempts would be unsuccessful.
2. Sufficient information (patient ledger, tickler note entries, copies of all letters should be provided to the collection agency.

3. Once an account is forwarded to a collection agency, all communication from the procedure center/billing office must stop. This includes any written communications as well as telephone contacts.

4. If a payment is received on a collection agency account:
   a. Do a correction of write-off for the full amount that the patient paid to the agency. Correction is labeled “collection payment received”.
   b. Apply payment equal to the actual money sent to the center from the agency (patient payment minus agency commission). Payment is labeled “payment from collections”.
   c. Apply write-off equal to commission withheld by agency. Label write-off “collections expense”.
   d. Account should equal zero again.

5. Uncollectible accounts for balances under $10 should be written off to bad debt and should not be placed with a collection agency.