**LOUISIANA STATE UNIVERSITY**
**HEALTH CARE SERVICES DIVISION**
**BATON ROUGE, LOUISIANA**

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| CONTENT: | Patient Accounts Receivable and Revenue Cycle Policy for the LSU Health Care Services Division |
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PATIENT ACCOUNTS RECEIVABLE AND REVENUE CYCLE POLICY

I. PURPOSE

This policy defines and establishes procedures to ensure effective management and monitoring of the hospital and clinic patient accounting/revenue cycle activity in order to support uniform billing, collection and reporting processes for the LSU Health System – Health Care Services Division (LSU-HCSD) Hospitals and clinics.

II. DEFINITIONS

A. REVENUE CYCLE

1. Financial Class: A code assigned in the patient accounting system that identifies the reimbursement source for the patients.

2. Insurance Plan: A code assigned in the patient accounting system that identifies the payer address to ensure proper billing and reimbursement processing, and maintained I the Payer Responsibility Master (PRM).

3. Centralized Charge Description Master (CCDM): The CCDM is a computer master file that serves as a link between the charge for the eservices provided and the generation of a claim form and the billing of the services. The CCDM includes a distinct charge service code, Common Procedural Terminology (CPT) code, revenue code as appropriate for available services and charge price.

4. Utilization Review/Case Management: Is the hospital department that promotes and fosters high quality patient care through concurrent analysis, review, and evaluation of clinical practices within the hospital.

III. POLICY AND PROCEDURES

**A.** It is the policy of LSU-HCSD for the Central Business Office (CBO) to produce an accurate and timely bill for reimbursement by the appropriate payer in compliance with payer specific guidelines, including Self-pay patients. It is also policy for the CBO to maintain proper monitoring and control of the billing and revenue cycle process. This includes measures to identify, prevent, and mitigate identity theft via detection and validation of relevant red flag alerts, through the correction of erroneous bills, and then notifying the individuals or authority as appropriate. Patients who are determined to be medically indigent for services at the LSU0-HCSD facilities are not billed for clinic, hospital, and/or the associated professional components. Bills generated for medically indigent patients will be

for statistical reporting of uncompensated care encounters and revenue only.

B. The LSU-HCSD management assigns accountability of all hospital departments involved in the revenue cycle to the hospital Chief Financial Officer (CFO) or designee. These departments typically include Admit, Registration and Screening, Medical Assistance Program (MAP), Utilization Review, Data Processing, HIS Coordinator, CDM Coordinator, Accounting, and Medical Records/Coding. However, oversight, direct reporting, and organizational structure may vary by hospital.

C. It is the responsibility of the Central Business Office (CBO) Director and Managers to ensure compliance to all sections of the Patient Accounts Receivable and Revenue Cycle Policy. The CBO shall communicate hospital operational concerns of possible non-compliance to the Chief Financial Officer or designee as needed to seek clarification, direction and/or assistance developing a corrective action plan.

A. REVENUE CYCLE

1. PATIENT'S FINANCIAL CLASS/INSURANCE PLAN CODE

*All patients shall be registered in the hospital's patient clinical and financial system. The patient/guarantor must provide demographic and financial information to determine payer responsibility, accurate assignment of financial class and insurance plan codes. The initial determination of the financial class/insurance plan code is the responsibility of the hospital Admit/Registration Department.*

*Revisions to financial classes/plan codes performed by CBO staff shall be updated in both the Patient Management (clinical) and Patient Accounting (financial) components of the hospital information system. Any revision of the primary financial class will include effective date of change and comments entered in the billing system. The financial class revision(s) shall be synchronized in the clinical and the financial systems with exception to inactive accounts in the clinical system.*

*The CBO Application Support section shall maintain all financial payer classifications as a standardized methodology. Financial class information shall be maintained through effective communication and coordination between Admit/Registration, CBO and Physician Billing contractor or hospital staff in order to maximize and*

*receive all reimbursement due the LSU-HCSD hospitals and physicians.*

2. SYSTEM PAYER RESPONSIBILITY MASTER

*The Payer Responsibility Master (PRM) shall be managed and maintained to ensure proper billing and calculation of expected reimbursement. Any addition to, correction of, or deletion from the PRM shall be submitted to the CBO Application Support staff responsible for authorizing maintenance of the PRM.*

3. SYSTEM PROFILE MAINTENANCE

*Master profiles within the hospital information system shall be maintained to ensure adequate and efficient billing for each payer. The CBO Application Support staff shall perform all profile maintenance on standardized profiles. Each hospital maintains their own Room and Bed Master.*

4. HOSPITAL CHARGE ENTRY

*All patients shall be accurately charged for all services provided at the LSU-HCSD hospitals, including inpatient and outpatient services, in compliance with state and federal regulations. The services must be authorized by means of an order from the patient's clinical practitioner, i.e., physician, physician assistant, and/or nurse practitioner. Charges will be entered through the hospital information system according to established charging guidelines following services being provided and prior to scheduled bill generation to prevent late charges. Charges are entered into the hospital information system through a variety of sources including: order entry, interfaces, point-of-service entry and data processing. Each chargeable service must be listed in the Centralized Charge Description Master (CCDM). The CBO Application Support CCDM staff maintains and manages the CCDM for the LSU-HCSD hospitals.*

5. CENTRALIZED CHARGE DESCRIPTION MASTER

*The LSU-HCSD hospitals' Charge Description Master (CDM) shall be maintained and reviewed at least annually for compliance with Healthcare Common Procedure Coding System/Common Procedural Terminology (HCPCS/CPT) coding and for pricing updates.*

*The CBO Application Support CCDM staff, in conjunction with the Hospital CDM Coordinators and assistance from Compliance Officers, and regulatory guidance with the Compliance Officers will review and make available any necessary changes to charge codes, their appropriate revenue codes, HCPCS/CPT codes, and any point-off logic designations based on payer billing requirements.*
*Hospital Department Directors and Managers are responsible for reviewing and requesting price updates on an annual basis.*

6. HOSPITAL UTILIZATION REVIEW

*Appropriateness of an inpatient admission, continued stay days, and extension of days shall be conducted on all payer classes by the hospital Utilization Review department.*

*Routine communication between Utilization Review, Admit/Registration, and the Central Business Office operations shall be maintained to ensure appropriate payer utilization review and that authorization for treatment regulations have been satisfied.*

*When non-medically necessary circumstances arise or instances of a "never event" occur, Utilization Review will notify the CBO so that appropriate billing to either the payer or the patient can occur or the determination of appropriate adjustment activity may be made.*

7. HOSPITAL MEDICAL RECORDS AND CODING

*The hospital Medical Records/Coding departments shall assist with the timeliness of bill production for each patient presented for services. In order to produce a timely bill, all diagnoses and procedure codes should be coded within five (5) working days from the patient's discharge date or service date, provided that all components necessary for coding are available. Hospitals have available via the information system the reports necessary for monitoring this performance standard.*

*Medical Records/Coding should only assign and report diagnoses and procedure codes that are consistent and clearly supported by physician, physician assistant, and/or nurse practitioner documentation in the patient's medical record. An International Classification of Diseases 9th Edition Clinical Modification (ICD-*

*9-CM) diagnosis and/or HCPCS/CPT procedure code should be assigned to all account financial class types in accordance with the standards of ethical coding requirements set forth by the American Hospital Association, Centers for Medicare and Medicaid Services, and American Health Information Management Association.*

*For accurate and timely submission of patient claims and reimbursement, Medical Records/Coding should provide the CBO any documentation requested within 10 working days of the request.*

8. MEDICAL STAFF

*It is the responsibility of the hospital to maintain and update the Doctor Master File in the hospital information system. All patient treatment, medical care, and chart completion shall be accomplished in accordance with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guidelines and the LSU-HCSD hospitals' Medical Staff By-Laws.*

*It is the responsibility of each of the LSU-HCSD hospitals' Medical Director or designees to ensure physician-credentialing information complies with policy and is routinely updated in the hospital information system by the responsible area.*

B. BILLING

1. PRE-BILLING

*All pre-billing errors shall be addressed within an average of one (1) working day (Tuesday through Friday) from the bill drop/receipt date, and an average of two (2) working days on Monday, when three (3) days of bills are received because of the weekend. Bill claim errors that are unable to be resolved will be identified and reported to the hospitals via the Patient Accounting Information Database (PAID) system as "Unbilled Claims" for resolution. Pre-Billing edits are built according to payer guidelines and include, but are not limited to:*

Diagnosis: accounts suspected of having missing or incorrect diagnosis codes based on charges present on the claim and /or payer feedback

Medical Records: accounts for which medical records are required for billing or which have been requested by the payer

Audit Charge Related: accounts for which an audit of coded charges is requested

Audit Med Record Related: accounts for which a review of the documentation in the patient's medical record is being requested

Audit PCP related: Medicaid accounts that require a Community Care referral in order to bill the claim to Louisiana Medicaid for payment

Audit Follow-Up: an audit is being requested by a member of the follow-up staff based on feedback from the payer

IP Medicaid Pre-Certs: services which require precertification from Louisiana Medicaid in order to obtain reimbursement on an inpatient stay

Outpatient Prior Auth: outpatient accounts requiring a prior authorization number, particularly for therapy services, prior to billing or when requested by the payer

PCP Referral Correction or Addition: accounts for which the Medicaid Community Care referral is either missing or incorrect based on payer feedback

Medicaid Consents Follow-up: accounts for which a Medicaid consent form is being requested due to payer feedback

Medicaid Spend Downs: accounts for which a copy of the Medicaid Spend Down form (110-MNP) is required for billing purposes

Services that are not medically necessary, not routine, not covered and/or excluded

Correct Coding Initiative (CCI) edits for units, modifiers, and unbundling

Potential overlaps of Outpatient/Inpatient and same day duplicate billings

Possible billing of duplicate claims for same services or bill submitted to more than one primary payer at the same time.

*Hospital staff is granted access to applicable audit types in the PAID systems that they may address those accounts that fall within their own area of responsibility. Coding and charging questions identified in the pre-billing process shall be referred to the hospital Nurse Auditor for review and direction of appropriate and accurate claim completion.*

## 2. UNIFORM BILLING

*The hospital information system generates uniform billing claim forms based on current healthcare payer regulations. Bill claim forms are populated through a combination of the information stored in various hospital system profiles and insurance plan designations. A Health Information Portability Accountability Act (HIPAA) compliant file of the uniform claims is created and sent from the hospital system into an electronic billing system.*

The number of claims submitted shall be reconciled daily utilizing system generated billing reports. The electronic billing system provides pre-billing payer edits identifying claim errors.

Once CBO and hospital staff has addressed the edits, bill claim forms are submitted to a clearinghouse that electronically submits claims to the various payers for processing.

When electronic processing is not available, a paper claim shall be printed and submitted to the payer for processing.

3. RE-BILLS

*As a standard practice, claims/charges should be re-billed within three (3) working days of identifying the need for claim re-submission, i.e., late charges, payer rejections, and/or payer denials.*

4. TIMELY BILLING

*When the payer information is provided in a timely manner, Inaccurate and timely bill shall be produced within a third party payers' timely filing requirement.*

A. Medicare Timely Filing

Medicare claims for dates of service after January 1, 2010 must be filed with the Medicare contractor no later than one calendar year (12 months) from the date of service

Claims for **dual eligible** recipients who have Medicare and Medicaid must be filed with the Medicare fiscal intermediary within 12 months from the date of service and **then** filed to Medicaid within 6 months of the Medicare paid date.

B. *Medicaid/Managed Care (MCO) Timely Filing*

Medicaid /MCO claims must be filed within 12 months of the date of service. KID MED screening claims must be filed within 60 days from the date of service.

Claims with a third-party payer and Medicaid/MCO shall be filed to Medicaid within 12 months of the date of service.

Providers submitting claims for dates of service over two (2) years old must provide proof of timely filing and must assure that claims were previously submitted to Medicaid within 12 months of the date of service and failure of claim payment was the fault of the Medicaid program or that claims were for a recipient with retroactive Medicaid eligibility.

C. *Commercial Timely Filing*

Commercial Insurance filing/billing guidelines are generally set for 180 days from the date of service. However, some payers may have a shorter filing/billing timeframe from the date of service i.e., some managed care contracts require a 90 day billing deadline.

Commercial insurance claims shall be filed within the healthcare payer specific guideline.

5. INDIRECT MEDICAL EDUCATION (IME) BILLING

*All LSU-HCSD teaching facilities who are receiving Medicare Graduate Medical Education (GME) funds shall bill the Medicare Intermediary for Indirect Medical Education (IME) supplemental payments for inpatient accounts when the beneficiary has medical coverage through a Medicare Advantage (MA) plan.*

*However, the Medicaid MCO prepaid health plans (Amerigroup, Amerihealth, Aetna Better Health, Caretas of LA, United Health Care and LA Healthcare Connections) do not reimburse the teaching facilities for GME.*

6. BILLING THIRD PARTY PAYER ON LIABILITY ACCOUNTS

*Liability accounts with Commercial health insurance plan coverage shall be billed to the appropriate payer as well as forwarded to HCSD-Legal. If the CBO has needed information regarding the third party liable then Medicare accounts without any liability payment after 120 days from the date of service should be billed to Medicare for a conditional payment.*

7. BILLING IDENTITY THEFT RED FLAGS

The following situations, in which the Hospital Patient Inquiry or Central Business Office may receive a question or complaint from a patient, should be treated as potential indicators of billing identity theft:

Patient received a bill or insurance explanation of benefit at their address that belongs to another patient;

Patient receives a bill or insurance receives claim for services that is inconsistent with hospital medical record documentation;

Patient denies receiving hospital or medical services on the date of service;

Patient receives insurance explanation of benefit for services never received;

Patient receives collection agency notice for services never received;

Insurance plan reports that the patient identified on hospital claim is not a member of the plan or coverage has exhausted or terminated;

Patient or insurance disputes hospital bill and charges because of a known identity theft situation experienced.

Prevention and Mitigation steps that should be taken by the Central Business Office are as follows:

Perform a thorough review of the account detail.
Make necessary and appropriate account or claim revisions.
Notify the patient involved or respond to inquiry or complaint.
Respond to fraud investigation authority.
Communicate situation to hospital management or notify legal authority when necessary.

## C. CASH

### 1. CASH HANDLING

*All hospital payments received should be posted into the patient accounting system and shall be deposited by the hospital within 24 hours of receipt as required by State Constitution, Article VII, and Section 9 (A).*

Acceptable payment methods include cash, check, money order and credit/debit card (Visa/Master & Discover Card).

The Patient Inquiry staff, located at all of the facilities, will post all payments using the Electronic On-Line Cash Posting system that will produce system generated pre-numbered receipts. If the computer system is down then pre-numbered hand written paper receipts, which support over-the-counter payments, will be utilized by the staff.

In addition, any checks received via U.S. Mail at the hospital Patient Inquiry Office shall be unopened and forwarded via U.S. Mail to the Lock Box for processing. All hospital payments received via Bank Lock Box shall be separately identified on the bank's electronic notification daily report.

*Cash-handling and record keeping functions should be separated to provide for reasonable and sound internal controls.*

CBO Cash Application Staff, who reconcile cash to receipts and account for overages and shortages, shall prepare daily Cash reports.

It is the responsibility of supervisory personnel to review cash-handling documents that are prepared by personnel who report to them.

All documents (including receipts, journals, logs, reports, checks and Insurance Explanations of Benefits) which are related to the bank deposit prepared by CBO Cash Application staff must be noted on the Cash Control Sheet, scanned into Document Imaging in the Daily Cash Folder, and routed to the Hospital Finance Department for reconciliation to the hospital financial accounting and the hospital information systems.

All procedures apply to other departments within the hospitals who handle cash, I.e., Cafeteria, and Medical Records.

2. CASH APPLICATION AND RECONCILIATION

*The CBO Cash Application staff will identify payment classification and post payments to the proper patient's account using the correct payment code. The amount of the payment posted should be reconciled to the deposit.*

*The Hospital Finance Department will reconcile the hospital information system with the hospital financial accounting system.*

*When payments cannot be identified for an account, hospital Admit/Registration staff shall establish a miscellaneous clearing account monthly in the hospital information system for posting unidentified payments in accordance with the requirement to record and deposit all payments within 24 hours of receipt. The miscellaneous account must be monitored monthly to ensure proper allocation of monies. The reconciliation of deposits to the general ledger should be completed on a daily basis but no less than once a week.*

3. ELECTRONIC PAYMENT POSTING RECONCILIATION

*The automated payment posting of electronic remittance advices should be reconciled weekly from the report date. This reconciliation shall be performed by using the 835 Payer Error Reports that identify payments not posted because the system could not locate an account on file. The CBO Cash Application staff shall conduct a manual search to identify the patient's account, ensure proper allocation of payment, and reconcile payments recorded on the bank deposit statement.*

*Payments are processed via Electronic Funds Transfers (EFT) to the bank and reconciliation to the hospital information system should be verified by the CBO Cash Posting staff with total claim payments as indicated on the remittance advice.*

4. PAYMENT/ADJUSTMENT SERVICE CODES

*Payment and adjustment codes are maintained for system automation application as defined in the hospital financial system profile and for manual application by CBO Cash Posting staff upon claim review.*

Payment codes are assigned to identify the specific payer category and should be applied accordingly.

Adjustment codes shall be applied in compliance with any contractual agreements and within State and Federal regulations as needed for account adjudication, maintaining an accurate accounts receivable, and achieving consistent reporting and monitoring by the hospital.

D. COLLECTIONS

Accurate and timely follow-up shall be conducted on accounts in compliance with payer specific guidelines and in an effort to maintain a proper account balance, responding appropriately to concerns and alerts that present possibilities of medical identity theft, researching and updating accounts in accordance with Federal, State and payer guidelines.

1. RECEIVABLE MANAGEMENT WORK STATION

The hospital information system's Receivable Management Workstation (RMW) is an available resource for CBO staff to utilize in efforts to increase cash collections and reduce accounts receivable. With RMW Supervisors and Managers can monitor productivity and assist with improving staff performance. RMW routes patient accounts to "collector work lists" according to parameters defined by the end user and should be utilized to identify problem accounts, perform procedures necessary to resolve account balances, and initiate action in an effort to prevent reoccurrence of payment delays. The accounts that appear on the RMW "collector worklist" should be worked daily to resolve outstanding patient account balances in Accounts Receivable. LSU-HCSD PFS/CBO Application Support performs RMW maintenance with coordination and approval from the CBO managers.

2. AGED TRIAL BALANCE

An Aged Trial Balance (ATB) is a monitoring tool that can be reviewed by the CBO managers/supervisors on a weekly/monthly basis to monitor accounts aging over 90 days from date of service and/or discharge date. Appropriate actions by the CBO staff should be initiated in an effort to maximize billing efforts and revenue collections, and to maintain national performance levels. The CBO uses national benchmarks to monitor perform standards for days in accounts receivable and percent of accounts receivable over 90 days. Any significant increases over these indicators should be reviewed and corrective action plans established.

3. PAYER REMITTANCE ADVICES

Payer Remittance Advices (RA's) and Explanation of Benefits (EOB's) are used for review in determining payer denials, non-covered services, and appropriate reimbursement. RA's and EOB's are both available for access in the document imaging system and on each hospital's Printer Support System (VPS).

4. DENIAL MANAGEMENT

All third party payer denials (excluding legal liability) shall be researched by CBO staff and corrective actions initiated within seven (7) working days of the denial date.

The CBO shall provide regular summary/trends of denials categorized by area using the American National Standard Institute (ANSI) Denial Reason Codes as a guide from both electronic remittances as well as non-electronic explanation of benefits posting.

The CBO utilizes the denial reports to identify areas for process improvements, and works with appropriate hospital departments to take a proactive approach in reducing all denied claims.

5. COLLECTION ATTORNEY

Prior to March 14, 2005 "Third Party Liability" accounts were assigned to an external collection attorney for the collection of monies owed to LSU HCSD hospitals. These cases were managed in accordance with Louisiana Title 46, Chapter 1 (including LA: R.S. 46:15).

As of March 14, 2005, all third party claims not in the external collection attorney's possession are the responsibility of the LSU HCSD third party liability internal legal staff, with the exception of any additional medical services that are a continuation of care related to a case previously assigned to the external collection attorney.

1. Procedurally, the CBO TPL staff supplies to requesting Attorneys copies of bills for medical services on all accounts classified as legal liability. When appropriately requested, hospitals will provide copies of medical records.

E. ACCOUNTS RECEIVABLES FOLLOW-UP

1. RECORD RETENTION

All financial documents and records relevant to supporting billed charges and reimbursement entries will be maintained by the hospital either in hard copy format or electronically in accordance with federal and state regulations. Hospitals and the CBO operation will retain records for a period of ten (10) years in compliance with the HCSD Record Retention Policy (0516-15). In addition, records shall be made available for reference by Centers for Medicare and Medicaid Services (CMS), Louisiana Department of Health and Hospitals, Legislative Auditors, or specially designated components for review, audit, and other references in accordance with state LA:RS 44:36, LA:RS 46:58, LA:RS 24:514, LA:RS 44:39.

A. Electronic Retention

1. Financial documents related to patient accounts shall be scanned into the document imaging system. Daily Cash transactions and all supporting financial and demographic documents related to patient account resolution shall be scanned and stored electronically as permitted in RS44:39 Section B, effective July 1, 1999.

2. DOCUMENTATION REQUIRMENTS

Patient accounts shall be documented with all account activity to maintain a chronological history of all account transactions and events. Patient account documentation should include but not be limited to: inquiries and requests from all sources, collection follow-up notes, reviews for payment/denial status, and updates to payer financial class, and patient demographic information revisions.

3. ADDITIONAL PAYER INFORMATION

In the event that a new or additional third party payer is identified during the billing or follow-up process, the new insurance plan and financial class must be added and any previously applied manual adjustments be reversed with the appropriate service code and the proper amount re-billed to the new payer.

It is the responsibility of CBO staff to ensure that both the Patient Financial and Patient Management components of the hospital information system are updated timely. CBO staff should access Patient Management components via the specially designed pathway that allows only third party payer information to be modified while protecting any medically indigent data captured during the registration process. A subsequent review of the account shall be conducted the following business day to verify that all transactions and payer updates were applied appropriately.

4. CHART AUDIT FINDINGS

Hospitals shall be compliant with federal and state regulations relative to incorrect or incomplete charge activity that resulted from hospital chart audits.

The hospital Nurse Auditor will be required to maintain a record of audit findings and to forward the results of the audit and interventions on all accounts to the Central Business Office to evaluate the need for a claim adjustment according to payer requirements and/or to initiate action for account resolution.

All audit findings must be documented and maintained as part of the patient account history, and all charge adjustments (debit and/or credit entries) shall be entered into the hospital's Patient Accounting information system by hospital staff.

5. COMMERCIAL PAYER DISCOUNTS

Discounts may be negotiated with a non-contracted or commercially insured patient's health insurance plan. The total amount owed for medical charges may be reduced in exchange for one of the following "acceptable" tangible economic benefits to the hospital:

A. Prompt Pay Discount

1. May be granted to non-contracted Payers who remit full discounted amounts owed prior to the actual remittance due date stated in the timely payment provisions of LA: RS 22:250.31.

B. Utilization Incentive Discount

1. May be granted to non-contracted Payers and contracted Payers (for non-contracted services) only when in the economic interest of the hospitals to increase utilization, revenue, and/or cash flow.

C. Settlement Discount

1. May be granted to non-contracted Payers when the legal obligation of the non-contracted Payer to pay the hospital does not exist or is doubtful.

Exclusions from consideration include: Third Party Liability case; payer with a direct contract with the hospital facility through PPO, HMO or similar managed care network; primary financial class of "Medicare", "Medicaid", "Free Care"; or claims already sent to "Collection Agency".

Assistance with negotiation efforts on these type discounts from total charges and reimbursement may be brought to the attention of HCSD Central Business Office for review and approval.

6. MEDICAL EDUCATION ALLOWANCE

Medical Education Hospitals may deem certain patients' surgeries to be "teaching cases" when the case is designated as such by the Hospital's Medical Director and the discount allowance is approved by the Hospital's Chief Financial Officer (CFO).

7. OVERLAPS BETWEEN FACILITIES

If it is determined during the course of an inpatient hospital stay that resources are not available to perform ordered medical services, it is appropriate for the patient to be transferred only upon physician order. The patient should be registered as an outpatient at the other facility that can provide the service. Once the procedure is complete, the patient should return as an inpatient to the original transferring hospital. The appropriate documentation should be maintained in the patient chart and charges invoiced to the transferring hospital so that the outpatient charges may be combined with the inpatient claim according to payer guidelines. "System facilities" as well as "outside facilities" should submit an invoice to the other facility for the services provided so that the transferring hospital can submit its claim to the payer with these charges included.

8. SMALL BALANCE ADJUSTMENT

The Patient Accounting system will automatically generate a small balance allowance for patient balances between $.01 and $9.99 if all insurance balances are zero.

9. BANKRUPTCY NOTICE

When a bankruptcy notice is received, all related patient account balances will be noted and collection activity stopped. Upon receipt of the notice of discharge, the account balance shall be resolved using the established bankruptcy adjustment "service code" in accordance with the specific chapter of bankruptcy as defined in the bankruptcy notice. If the patient is dismissed by the bankruptcy court then the account will be coded as due and payable by the patient.

10. PATIENT DECEASED

Outstanding patient account balances shall be manually transferred to archive status when the hospital obtains information verifying the patient is deceased (death certificate), proof of no surviving spouse, no estate, and/or open succession with the Clerk of Court.

If the prior stated conditions are not met, a death certificate and a notarized statement from a family member or acquaintance stating that there is no estate to liquidate hospital bills should be used as documentation for this purpose and process.

11. MEDICAL MALPRACTICE

The HCSD Legal Department handles the billing of a medical malpractice claims or suits (refer to Disposition of Medical Bills in the Settlement of a Medical Malpractice Claim or Suit Policy and Procedure 7001-15).

12. PRESCRIBED ACCOUNT

Typically, healthcare providers adhere to the Fair Debt Collection Practices Act and the Federal Trade Commission in connection with normal follow-up and collection activity on outstanding patient account balances. Therefore, outstanding delinquent patient accounts that have had no collection or payment activity within three (3) years from the date of service are considered uncollectible and deemed a prescribed debt. However, in the State healthcare system, in many situations prescription does not run against debts owed the State in civil matters. HCSD hospitals with any outstanding patient account balances over three (3) years from the date of service or the date of last payment should be considered for archived through the bad debt file.

13. ADMINISTRATIVE ADJUSTMENT

The Hospital Administrator has the authority to approve an administrative allowance on account balances of $25.00 or less. Authorization to adjust accounts in excess of $25.00 must be submitted with written justification to the HCSD Patient Financial Services Director who presents the requests to the HCSD Chief Executive Officer or designee for final approval.

14. TRANSFERRING ACCOUNTS TO ARCHIVE

An account with a zero balance will transfer to archive 32 days from the date it becomes a zero balance account. Only non-liability bad debt accounts will automatically transfer to archive after 540 days of no activity. Bad debt accounts are the only accounts that will transfer to archive with a balance. Any account manually forced to archive with a balance will have a system-generated allowance posted that brings the account balance to zero.

15. REFUND

It is the responsibility of CBO staff to conduct a timely review of credit balance accounts, to determine the cause of the credit balance and appropriately resolve the credit. If it is determined that inappropriate payments or overpayments were received, a refund should be initiated and tracked to ensure the timely refunding and resolution of the credit.

Insurance payer guidelines that require the sending of adjusted or voided claims should be adhered to when appropriate and/or necessary. As a Patient Accounting standard, all requests for a refund received via telephone or U.S. mail should be addressed within 10 working days from the receipt date.

The Medicare Quarterly Credit Balance reporting shall be completed within the Centers for Medicare and Medicaid Services (CMS) mandated requirements.

16. RETURN MAIL

The Patient Inquiry staff at the hospitals should work with Admit/Registration staff to ensure that all return mail is routinely corrected and the patient account documented with an updated status. When statements and/or mail is returned with a "Forwarding Address", the guarantor and patient demographic information should be manually

updated on the account through the Patient Accounting system (financial system).

To detect possible red flags of identity theft, change of address requests not supplied by the US Postal system must be validated for authenticity. When no forwarding address is given, a statement code of "N" should be applied to the account to suspend future statements. The account should then be skip traced using all available tools, following the return mail process/procedure.

When a corrected address is found, the Patient Accounting system should be updated and the statement code of "N" removed. When a corrected address cannot be found for the guarantor, the account should be transferred to the collection agency for further skip tracing efforts and collection.

F. ACCOUNT FLOW

A patient's account balance will automatically transfer from one payer plan to the next payer plan and the financial class changed to the patient's responsibility or bad debt as appropriate, based on payment activity status. Self-pay accounts with no payment activity after 60 days should qualify for bad debt and transfer to the collection agency on a weekly basis.

1. Medically Indigent (Free Care)

A system-generated transaction will post the Medically Indigent adjustment to the patient account at final bill or at the point of bill generation, leaving a zero account balance. The account will be moved to the patient accounts archive file 32 days after the account is a zero balance account.

2. Prisoners

When the patient is a prisoner without commercial insurance or Medicaid coverage and is housed in any parish or municipal jail, detention facility, or State prison, a system-generated transaction will post the Prisoner Care adjustment to the patient account at final bill or upon bill generation, leaving a zero account balance.

Additionally, all inpatient State prisoners without insurance or Medicaid will be referred to the Medicaid Application Program (MAP) unit for possible Medicaid eligibility. All Federal Prison patients are billed to the U.S. Marshall or Federal Prison and account follow-up performed in the same manner as a Commercial insurance account.

3. Liability

When the CBO Third Party Liability receives an Attorney request, the staff prepares a copy of the claim and other pertinent liability information and files the appropriate liens. If no payment is received within 150 days, the account is automatically reclassified as liability bad debt, transferred to the bad debt file and remains in bad debt until the account balance reaches a zero status or is manually reclassified.

4. Medicaid

When the patient account balance is greater than zero after 21 days from the final bill date, the account will be routed to Receivable Management Workstation (RMW) for collector review. Final billed accounts will continue to route to RMW every three (3) weeks until the balance becomes zero or is manually reclassified. Separately, inpatient accounts with charges > $10,000 and outpatient accounts with charges > $5,000 are routed to RMW weekly for review.

5. Medicare

When the patient account balance is greater than zero after 25 days from the final bill date, the account will be initially routed to RMW for collector review. Final billed accounts will continue to route to RMW every three (3) weeks until the balance reaches a zero status or is manually reclassified. Separately, inpatient accounts with charges > $10,000 and outpatient accounts with charges > $5,000 are routed to RMW weekly for review.

6. Commercial/ Managed Care (Includes Grants)

When the patient account balance is greater than zero after 21 days from the final bill date, the account will be initially routed to Receivable Management Workstation (RMW) for collector review. Final billed accounts will continue to route to RMW every three (3) weeks until the balance reaches a zero status or is manually reclassified. Separately, inpatient accounts with charges > $10,000 and outpatient accounts with charges > $5,000 are routed to RMW weekly for review.

Crime Victim Reparations (CVR) and Sexual Assault Nurse Examiner (SANE)

These accounts are treated like a grant/sponsored program which is established for care of the victim according to the plan's benefits. The hospital's limited payment amount is paid only after the patient's primary insurance has paid.

On Registration, in addition to any primary insurance plan code, the appropriate CVR/SANE insurance plan code should be utilized.

The account will be billed utilizing the primary insurance and then the CVR/SANE claim form with the itemized bill.

The CVR/SANE Board/Program makes the determination to pay an account and all correspondence/information the program needs to process the claim are sent directly to the patient who must cooperate and fulfill all requests.

The patient is responsible for filing a police report and cooperating with the law enforcement to be eligible for the CVR/SANE program.

(A) The hospital nurse examiner should clearly explain and inform patients of their responsibility cooperate by providing all information when requested from both their primary insurance and the CVR/SANE program.

If not payment is received from their primary insurance or the CVR/SANE program, the patient will be responsible for the total hospital charges.

7. Workers' Compensation

When the patient account balance is greater than zero after 15 days from the final bill date, the account will be initially routed to RMW for collector review. Final billed accounts will continue to route to RMW every three (3) weeks until the balance reaches a zero status or is manually reclassified. Separately, inpatient accounts with charges > $10,000 and outpatient accounts with charges > $5,000 are routed to RMW weekly for review.

The patient is typically not held responsible for any hospital or clinic charges incurred related to this injury unless, the patient refuses to comply with employer and hospital policies and procedures related to Worker's Compensation.

8. Self-Pay

All self-pay patients are entitled to receive a discount on all eligible charges for any non-bad debt self-pay patient account, when the negotiated account balance is paid in full and/or have completely agreed upon payment plan terms.

Elective cosmetic, fertility, and/or special flat fee programs are not eligible for the Self-Pay discount, in accordance with the HCSD Self-pay Discount Policy, 2530-15).

The Patient Inquiry staff should as appropriate combine multiple Self-Pay account balances to a single "master account" when establishing contract arrangements and a minimum monthly payment plan option for the patient.

9. Statements

The hospital patient accounting system generates a series of three (3) patient collection statements with appropriate dunning messages to the patient and/or guarantor on any outstanding account balance due for services rendered. After the initial statement, subsequent statements are generated in 30-day increments.

All Self-Pay payment arrangement accounts that are transferred to the collection agency functioning as our "extended office" service will receive monthly statements from the agency.

10. Bad Debt

After three (3) collection statements are issued to the guarantor, if no monthly payment is received after 90 days from the final bill date or financial class change date, the account will be transferred to the First Placement Collection Agency in 7 days.. The first collection agency will pursue collection of the account balance for a period of 180 days. If no payment is received, the accounts are forwarded by the first collection agency to the Second Placement Collection Agency. Accounts are automatically moved to the patient account receivable archive file after 540 days in bad debt.

The contracted collection agencies are allowed to offer a "quick pay" account balance reduction on self-pay bad debt accounts placed for collection. A reduction of this type is of economic value to the LSU-HCSD hospitals and provides the patient or guarantor an incentive to consider paying an outstanding account balance that would otherwise not be paid.

11. Medicare "Medically Indigent" Bad Debt

Medicare patients who qualify as medically indigent ("free care") after Medicare may be considered a Medicare bad debt. It is important that the medically indigent secondary balances (deductible and co-insurance only) are adjusted to the appropriate medically indigent designated adjustment code in a timely fashion to ensure that they are included in the cost report figures for the year in which the Medicare bad debt was incurred.

The Second Placement Collection Agency is required to close and return as uncollectible balances to LSU HCSD all accounts greater than $10,000 after 180 days from the date of receipt if an account does not have a payment arrangement. The Medicare accounts with reportable deductible, coinsurance and lifetime reserve amounts will be claimed as Medicare Bad Debts to the fiscal intermediary on an annual basis. The amounts reported will be less any payments received during the accounts active collection period.

## G. ACCOUNTS RECEIVABLE QUARTERLY REPORTING

As required by LA.R.S. 39:79, the Quarterly Accounts Receivable and Debt Owed Reporting of all Self-pay and Commercial Insurance financial class accounts receivable shall be submitted for each LSU-HCSD hospital as of the end of each quarter. The quarterly report shall be prepared by the HCSD PFS/CBO – Application Support section and provided to the HCSD Patient Financial Services Director for review and signature for submission to the Office of Statewide Accounting and Reporting by the last day of the month preceding the end of the quarter.

## H. SECURITY FOR SYSTEM ACCESS OF PATIENT INFORMATION

Security for employee access to patient information through the hospital system shall be assigned by LSU-HCSD Information Services staff, through the Hospital Information Services (HIS) Coordinator or designee, who will maintain a file to include the access granted for the approved applications in accordance with JCAHO, federal and state guidelines. Contractors and outside agencies' are assigned "view only" access to Patient Management and Patient Accounting and their security access is maintained through HCSD CBO Application Support staff. Upon termination of an employee or a contract, access to patient information shall be revoked by the HIS Coordinator or designee at the time of termination.

## I. COMPLIANCE RISK

Routine efforts should be made to avoid certain issues and/or situations that may be non- compliant or pose a potential risk to any patient, employee and/or the organization. However, if a situation arises it should be reported to the immediate supervisor. The supervisor should initiate a request with the appropriate Compliance Officer for a full review and investigation. The department should maintain high quality review and evaluation standards in order to avoid any penalties that could be issued by OIG, CMS and/or DHH.

Effective communication between the Compliance Officer(s) and the CBO shall be maintained in order to resolve any potential compliance issue and to incorporate into existing processes measures for medical identity theft detection, correction, prevention and mitigation.

## IV. APPLICABILITY

This policy shall apply to all divisions, hospitals and clinics under the direction and responsibility of the LSU Health System – health Care Services Division (LSU-HCSD).

## V. IMPLEMENTATION

This policy becomes effective upon the approval and the signature of the Chief Executive Officer (CEO) of LSU-HCSD. Subsequent revisions to this policy shall become effective on the date the revised policies are approved by the Chief Executive Officer of LSU-HCSD or designee.

## VI. RESPONSIBILITY

It shall be the responsibility of each Division Director and Hospital Administrator or designee(s) to adhere to the procedures set forth in this policy.