



## Policy

**TITLE:** Patient Billing and Collection Process

**APPROVAL DATE:** 05/05/2022

**APPROVER(S):** Stephanie Wells (Sys VP-Revenue Cycle)

**NUMBER:** OHS.REV.044

**APPLICABLE TO:** Ochsner Baptist - A Campus of Ochsner Medical Center, Ochsner Health, Ochsner Medical Center, Ochsner Medical Center - Baton Rouge, Ochsner Medical Center - Hancock, Ochsner Medical Center - Kenner, Ochsner Medical Center - Northshore, Ochsner Medical Center - West Bank Campus, Ochsner St. Anne Hospital, Ochsner St. Mary, OLG - Ochsner Abrom Kaplan Memorial Hospital, OLG - Ochsner Acadia General Hospital, OLG - Ochsner American Legion Hospital, OLG - Ochsner Lafayette General, OLG - Ochsner Lafayette General Medical Center, OLG - Ochsner St. Martin Hospital, OLG - Ochsner University Hospital and Clinics, Rush - Ochsner Choctaw General, Rush - Ochsner Laird Hospital, Rush - Ochsner Rush Health, Rush - Ochsner Rush Medical Center, Rush - Ochsner Scott Regional, Rush - Ochsner Specialty Hospital, Rush - Ochsner Stennis Hospital, Rush - Ochsner Watkins Hospital

### I. Purpose

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

### II. Definitions

- A. Balance Billing - when a provider bills you difference between the total cost of services and the allowed amount. This typically happens with out-of-network (non-contracted) providers
- B. Early Out Vendor - Outside agency responsible for the outsourcing of collection attempts prior to being considered bad debt.
- C. Guarantor - 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). In many cases, the patient is the Guarantor.
- D. Organization – (i) Ochsner Clinic Foundation d/b/a Ochsner Health (“OCF”), (ii) all entities that are wholly-owned or controlled by, or under common control with Ochsner Clinic Foundation (“OCF Affiliates”); (iii) all facilities wholly-owned, leased, and/or managed by OCF or an OCF Affiliate; and (iv) all workforce members in an Ochsner facility.
- E. Out-of-network - Describes providers and facilities that haven’t signed a contract with your health plan.
- F. Surprise Billing - An unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.



### III. Policy Statements

The Organization is committed to following a consistent approach to notify all Guarantors of financial responsibility and provide 120 days to resolve account balances before transferring accounts to bad debt. The steps in the collection process include statements, telephone calls, letters, online bill pay and access to a customer service operation which can provide assistance regarding billing inquiries. The Organization does not engage in balance billing practices and assesses patient balances in accordance with the amount indicated on the explanation of benefits provided by their insurance plan. In addition, the Organization does not engage in extraordinary collection actions.

### IV. Policy Implementation

#### A. Statements

1. Statements are generated within 28 business days of determination of patient responsibility.
2. A minimum of 4 patient statements are sent based on a 28-day cycle.
3. Patients will not be sent a statement for any balances not previously billed to the patient within 15 months of determination of patient responsibility. These amounts will be adjusted as untimely transfer to patient responsibility.

#### B. Additional collection activity process

1. Within 30 business days from the date Guarantor financial responsibility is determined, accounts will become eligible for outbound collection calls which may either be made in house or by an Early Out Vendor.
2. After 60 days of remaining as an open balance, accounts will be placed with an Early Out Vendor.
3. Accounts remain with the Early Out Vendor until the outstanding balance reaches 120 days and 4 statements have been sent

#### C. Bad debt determination and transfer process

1. Accounts qualify for bad debt placement when the account balance is outstanding for a minimum of 120 days from the Guarantor's first statement date.
2. Bad debt accounts are placed with one primary collection agency for further follow-up through automated and manual processes.
  - a. The collection agency is authorized to send legal letters and make outbound telephone calls.
  - b. Collection attempts are made by the primary agency for a minimum of 180 days from the date of placement.
  - c. On day 181, unresolved accounts or accounts not on an active payment arrangement are closed and returned.
3. Accounts closed and returned from the first collection agency are then placed with a secondary agency and are worked for a period of 6 months (*excluding Leonard J. Chabert Medical Center, which if unresolved are closed and returned after the first placement*).

- a. After 6 months with the secondary agency, accounts with an outstanding balance are closed and returned to the Organization to be tagged as uncollectible bad debt in the patient accounting system.

D. Uninsured Discount

1. Uninsured patients are automatically eligible for a discount of total charges for hospital services. 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 discounts are facility specific and represent the average payor yield by reviewing Medicare and commercial actual and expected payments (including the patient portion) over a year period.
- E. Early placement to an outside collection agency may be determined by a representative regardless of age for the following reasons:
1. Mail Returns/Skips.
  2. Deceased/Successions
    - a. In compliance with Medicare guidelines, The Organization shall cease billing processes once formal notification of the death of a guarantor is received.
    - b. 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.
  3. Patient payment plan defaults and loan program recourse.
- F. Some accounts are not sent to collection agencies based on pre-determined criteria. Examples of accounts included in the offload rules are:
4. International
  5. Research Study
  6. Hospice
- G. Requests for exception to this policy must be submitted to the leader of Guarantor Follow-up of and describe the reasons for requesting the exception.
- H. Indigent Bad Debt
- a. Medical Indigence for traditional Medicare patients will be determined by an individual assessment of financial need to include:
    - i. Application Process ("Attachment A"), in which the patient or the patient guarantor, is required to cooperate and provide personal financial and other information and documentation relevant to making a determination of financial need.

## **V. Enforcement**

Failure to comply with this policy may result in progressive discipline up to and including termination of employment for employees or termination of contract or service for third-party personnel, students or volunteers.

## **VI. Attachments**

*This section intentionally left blank.*

## **VII. References**

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## **VIII. Policy History**

Bad Debt Determination and Transfer	ISOP-HCA-01
Guarantor's Collection Process	ISOP-CCA-02