POLICY AND PROCEDURES **POSTED: 07/22/2021**

SUBJECT: ACCOUNTS RECEIVABLE **REVIEWED: 8/31/2021**

REVISED:

SCOPE: Applies to all full and part-time personnel representing LCEMS in any capacity.

PURPOSE: To ensure that Livingston County EMS Personnel properly report, record, and manage claims.

POLICY: It is the intention of LCEMS that each request for a response generate a unique identifier or incident number and that each identifier shall follow this procedure to ensure that all response requests are processed with the same standard. This standard will ensure that all response requests are treated equitably.

The County is equal opportunity employer and adheres to nondiscrimination in its practices.

PROCEDURE:

1. Each response request MUST be reported to Livingston County Central Dispatch (LCCD) for recording purposes. If the response request is form another source the information must be transmitted to LCCD and an EMS incident number assigned to it.

2. The next step is to ensure that each response request has a corresponding electronic patient care record (EPCR). This will be the responsibility of the field supervisors to follow up on each unmatched CAD record. The only calls that do not require a matching EPCR are canceled calls and calls with no patient found.

3. The EPCR's will then flow through a quality improvement process to ensure that that they are complete and accurate. Incomplete or inaccurate reports shall be returned to the author for correction or completion according to LCEMS documentation policy and MCA guidelines ( ).

4. All EPCR's will then flow through in to the billing software. The quality Improvement Specialist will ensure that all EPCR's in the system are processed through to the EMS billing system.

5. Once in the EMS billing system the EPCR's will distribute to individual Billing Specialist's workflow.

6. During the Payer Verification process (further referred to as PV), the patient demographics are verified and insurance is loaded in for billing. Signatures are verified and notes per each individual insurance's guidelines for billing are added and followed. Calls that do not have enough information to bill will be placed on hold and a FIN (hospital obtained demographics -requested via fax) or RFI (Request for Information - mailed to patient) requested. Once the FIN or RFI is returned with the missing information, it is added to the call and moved forward to be billed. If the FIN or RFI is not returned or incomplete, the call is billed "self-pay".

7. During the Billing Verification process (further referred to as BV), the Billing Specialist will read the EPCR (Electronic Patient Care Report), evaluate for any QI holds, Medical Necessity or errors, and if found that the EPCR is complete, the call will be coded and sent to batch. If

the call is incomplete, it will be placed on QI hold to be rerouted back for corrections. Once QI holds are corrected, the call will come back to BV for billing.

8. At the end of each business day, batch will be processed. Each claim will be in a designated holding area with all other claims billing out to the same insurance companies. Batch will be sent. These claims will now turn into invoices and have accounts created in Account Inquiry as an open invoice. Some claims will process electronically and some will have to be printed and mailed. The batch que will indicate which way they need to be processed.

9. Through our billing software contract, our claims are scanned electronically through the clearing house for front end rejections. The clearing house is checked weekly for these rejections by the Billing Specialist and Revenue Cycle & Compliance Manager . If there are errors identified and the claim can be resolved through the clearing house, the claim can be corrected and re sent. If the claim requires more edits than manageable through the clearing house, the claim is corrected and re billed through our billing software to go back through for front end rejections. If the claim rejects for an eligibility error, there are some cases where we note the error in the comments section in our billing software and switch the billing to self-pay. This is where we would need more information from the patient.

10. Our billing software is tied to our clearing house and we work with the county Tyler Munis accounting program. When EFT's (Electronic Fund Transfers) come in through Tyler Munis, and the day is settled, the General Ledger report is printed. This report displays all of the payments that were posted to the EMS account. The report totals for each entry are located in the clearing house software and then in cash receipts of the billing software and processed. All of the contractual amounts are entered and the balances are verified with the EOB's (Explanation of Benefit) from the insurance companies that are attached to the clearing house payment lines as break downs to what was paid on each claim. Once the cash receipt is verified and closed, the balances will either generate self-pay invoices or secondary claims (3^{rd} or 4^{th}) claims.

11. We are contracted with Medicare, Medicaid, the Blues and PHP. We accept the allowable on these invoices. Workers Compensation is also accepted at the allowed amount. When we are NOT contracted and there is a negotiated discount/ PPO discount or reduced invoice amount, that is patient responsibility. We also bill all co-pays, co-insurances, cost sharing and deductibles to the patient as indicated on their EOB's. (With the exception of COVID, because we accepted the CARES money, these would be written off in house if the patient was COVID + or signs/symptoms).

12. We also receive rejections on claims that processed all of the way to the insurance companies. These come in paper form through the mail or electronically as "zero" payments on the clearing house software. These rejections are worked in the patients favor, as it is best practice to get payment from the insurance company before sending to the patient. We will

get record requests, deductible amounts not met, member coverage termed, no claim found, not a covered benefit, non-emergency ambulance coverage not on policy, benefits exhausted, etc. as some examples. These rejections are all worked, and scanned to the EOB folder on the county network, with notes in the comments of the call. Sometimes a rejection cannot be resolved and a self-pay invoice needs to go to the patient for additional help getting their claim paid.

13. When there is a self-pay balance due, our billing software is programmed to print a series of three invoices to go out to the patient at 30-day intervals. Invoices are hand stuffed into envelopes with additional information needing to go to the patient such as HIPAA forms, blanket RFI, survey slips and envelopes. There is specific verbiage printed at the bottom of each statement explaining how to make a payment or call the office to add insurance information if it has not been billed, or call the office to set up a payment plan. The third invoice indicates that we are 60 days out with no patient contact and now it is their FINAL NOTICE. There is also an additional paper insert FINAL NOTICE that is included to get their attention. It states that if you do not contact us within 30 days, this invoice will be turned over to collections and an additional 25% maybe added on to the balance. If the patient calls to make payment arrangements or request financial hardship, the billing statement count is reset back to one, and the series of invoices generates again, allowing the patient to begin to make their monthly payments or have time to gather documents and return the Financial Hardship form to the EMS business office for review by the Director.

14. When there is no activity on an account for 90 days, it will end up in Final Dunning. This is the last attempt to work the claim before it moves on to the collection agency. During this process, Billing Specialists verify that the patient is not deceased, there is no Medicaid or back dated /provided insurance that may have been added after it was first billed. A courtesy check can be performed on EPIC (hospital-based demographics) for insurance updates or request FINs. Billing Specialists can also send one more highlighted invoice to get the patients attention before moving to the collection batch. If the patients bill is under $35, the bill is considered under the dollar threshold warranting collection efforts. The Revenue Cycle & Compliance Manager will create the adjustment on the account to zero out the patient balance. Report will be given to the Treasurer of these “small balance adjustments”. Frequency of reporting will be determined based on the Treasurer’s need.

15. If the patient is not deceased, does not have Medicaid, not work comp, psych transfer or special notes on the call, the Billing Specialist can forward the call to the collections batch. If there are special notes to review, the call is put on HOLD for the Revenue Cycle & Compliance Manager to review before sending to the collection batch or directing the call to the EMS Director for review. Depending on how many invoices are in the collection batch determines

if it is sent weekly or bi-weekly. We upload the accounts that we are sending to collections per their process.

16. When the accounts are acknowledged by the collection agency, the Revenue Cycle & Compliance Manager and/or Office Manager will write-off the balance on accounts sent with a comment of "collections". This will zero out the patient account. Report will be given to the Treasurer regarding the dollar amounts written off. Frequency of reporting will be determined based on Treasurer need.

17. If the account is in full collect with the collection agency and we receive a payment, we will deposit the payment into the "Collections-Written Off Accounts" revenue line item and email our patient account representative at the collection agency the amount that was paid. The collection agency adjusts the amounts based on the % of the amount that is owed to them. The Revenue Cycle & Compliance Manager will put notes on the account of any payments that were forwarded to collections and who the payment was reported to without altering a patient account balance.

18. Payments received from the collection agency will be receipted to the "Collections-Written Off Accounts" revenue line item. There will be no altering a patient account balance when the collection agency forwards payment.