

# FINANCIAL MANAGEMENT 2.0

## Accounts Receivable -- 2.7

### 3<sup>rd</sup> Party and Individual Patient Billing--2.7.a

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**Date Issued:** January 2001

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**Revised:**

**Signature:**

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Assistant Commissioner  
Bureau of Health Services

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#### **POLICY**

Service provided to individual patients will be billed according to the guidelines set forth in this policy. Services which are reimbursed by third-party payment sources, such as TennCare, CHAMPUS, Medicare, or private insurance, will not be billed to an individual patient account unless 1) the service is denied by the third party payment sources as non-allowable; 2) a co-payment or deductible amount is indicated; 3) no response is received from a third-party payment source (excluding TennCare) after two 60-day notices; 4) the service is provided to non-TennCare patients with private insurance where the region has been granted a waiver for billing private insurance as described in [policy 2.7.h - Waiving Private Insurance Billing \(Non-TennCare Enrollees\)](#); or 5) the service is provided to patients who are enrolled in a third-party plan that the local health department is not authorized to bill.

In these five instances the charges will be transferred to the individual patient's account and are subject to the collection procedures described in [2.7.f – Collection and Write-off of Accounts Receivables](#).

#### **APPLICABILITY**

This policy applies to Local Health Department, Regional and Central Office personnel.

## PURPOSE

To establish equitable and sound guidelines for the billing of fees for services rendered to all individual patients.

## PROCEDURE

The following procedures must be used for maintenance of Accounts Receivable which arise from TennCare, CHAMPUS, Medicare, Medicare/TennCare, private insurance, and fees due from individual patients:

1. **TennCare:** If the balance of an account is billed to a Managed Care Organization (MCO) and the MCO pays its allowed amount, the balance will be adjusted to zero with the exception of co-payments and deductibles which are the patients' responsibility. However, if the balance of an account that is billed to the MCO is denied by the MCO as non-allowable, the individual patient will be billed based on the sliding fee schedule, if applicable.
2. **Denial Due to Health Department Error:** If the reason for the denial of payment is attributable to an error on the part of the health department, the patient will not be charged the non-allowable amount.
3. **Non-allowable Charges, Co-payments, and Deductibles:** The patient can be billed for non-allowable charges if they are non-covered services under the patient's benefit package. In such cases, charges for the service shall be subject to any applicable sliding fee schedule adjustments. All co-payments and deductibles should be charged in their entirety to the patient as described in [policy 2.7.b](#) and [2.7.c](#).
4. **CHAMPUS or Medicare:** If the balance of any account is billed to CHAMPUS or Medicare and the allowed amount is paid, the balance will be adjusted to zero except for the co-payment and deductible amounts which will be billed in their entirety to the individual patient. However, if the balance of an account that is billed to CHAMPUS or Medicare is denied as non-allowable, the amount is billed to the individual patient based on the sliding fee schedule, if applicable.
5. **Medicare/TennCare:** Medicare must be billed initially; any unpaid balance, along with a remittance advice, should be billed to the MCO. If the balance of a Medicare account has the deductible and co-insurance billed to the Bureau of TennCare and the Bureau of TennCare pays the allowed amount, the balance will be adjusted to zero, and no individual collection effort is required. All co-payments and deductibles for non-Medicaid enrollees should be charged in their entirety to the patient.
6. **Private Insurance:** If the balance of an account is billed to private insurance and private insurance pays the allowed amount, the disallowed amount will be billed to the individual patient based on the sliding fee schedule, if applicable.
7. **Patients having both Private Insurance and TennCare:** If a patient has both private insurance and TennCare, private insurance must be billed first if the patient does not have an assigned/network provider arranged through their private insurance. See [policy 2.7.d - Billing for patients who have TennCare and Private Insurance](#).

8. No third-party response: After a 60-day period of receiving no response from a third-party payor (excluding TennCare), a written notice of payment due will be sent. **After another 60-day period of no response a second notice will be sent or a documented phone call will be made.** If no response has been received within 60 days after the second notice, then the individual patient will be billed based on the sliding fee schedule, if applicable.
9. Services provided to Non-TennCare patients with Private Insurance: Where the region has been granted a waiver for the billing of Private Insurance: See policy 2.7.h -Waiving Billing Private Insurance (Non-TennCare Enrollees), then the individual patient will be billed based on the sliding fee schedule, if applicable.
10. Patients Requesting Local Health Department Services in lieu of Receiving Services from their Assigned/Network Provider: Local health departments may refuse to serve patients who are enrolled in a third-party plan that the local health department is not authorized to bill. If the patient insists upon receiving services at the health department and the health department is willing to see the patient, the patient will be assessed the full charge for services provided with no slide applied. See policy 2.7.e – Patients Requesting Local Health Department Services in lieu of Receiving Services from their Assigned/Network Provider.
11. **If an encounter error is discovered that results in additional charges to a patient's private pay account after the patient has paid or has been informed of their charges, then the additional charges will be adjusted the patient's account.**

## REFERENCE DOCUMENTS

1. Rules of the Department of Health, Chapter 1200-17-2.
2. Rules of the Department of Finance and Administration, Division of Accounts, Chapter 0620-1-9
3. Medicare Provider Reimbursement Manual, Part I, Section 310

## OFFICE OF PRIMARY RESPONSIBILITY

Fiscal Services Section, Bureau of Health Services, (615)741-7305