NO-FAULT
DAY-ONE BILLING AND FOLLOW-UP PROCEDURES

Due to the 45-day submission limitation we are forced to act quickly to obtain the UB92, Medical Record and Insurance information. Since the average Hospital has a 5-day hold on all outpatient accounts the time limitation is actually 40 days.

Our office recommends the following forms be given to each patient that is registered in the Financial Class, "No-Fault".

1. No-Fault AOB
2. No-Fault request for information.

Once our office receives placement of new work, we will submit a request to the Facility's Medical Records Department, either by fax or email. Our field representative will come to your Facility and copy the Medical charts necessary for claim submission.

Insurance information requested from the patient

If the patient does not supply your Facility with the Insurance information, our office will attempt to contact the patient at home or work, obtain the police report and immediately start a letter series (request for no-fault information questionnaire). There are a total of three letters all within 35 days. If we continue to receive no response from the patient, the account is transferred into a self-pay status and the self-pay letter series will commence. This letter series specifies that the patient is responsible for the bill due to non-compliance with the rules and regulations of the New York State No-Fault Law. If the patient does not respond, our office will close and return the account to your Facility for further processing.

No-Fault application not received from the patient

If reimbursement of a claim is pending receipt of the No-fault application, we will attempt to contact the patient directly to complete the application over the phone. If we are unsuccessful a letter series will commence, attached to the letter will be a blank NF-5 (application) attached. These letters explain to the patient that without receipt of the application, the bill will not be paid by their Insurance Company and they will be responsible for payment of the bill if it is not submitted within the time limit.

Policy violation

Once the Insurance Carrier denies the claim, for a policy violation, the account will be transferred into a self-pay status. The patient will then be contacted by phone and mail to remit payment. If the patient supplies us with Health Insurance information, we will submit the bill to the Health Insurance and notify the patient that if the health Insurance does not pay the claim they will be responsible for payment.

Claim submission to the Insurance Company

Submission of all claims is done either by fax, mail or hand delivered by our Field representative. Over 90% of our claims are faxed to the Insurance Companies; this process not only provides us with proof of submission, but also minimizes the turn around time for payment.

Claims not paid within 30 days

Any claim submitted to the Insurance Carrier and not paid within 30 days, will be expected to be processed with interest, based on the N.Y.S. guidelines. When contact is made with the Insurance Carrier during our follow-up of the account, they will be notified that unless payment is made within 10 days, we will be filing a complaint with the Department of Insurance, due to no compliance with the N.Y.S. Law.

Claims rejected for medical necessity

Once an account is rejected for medical necessity we contact the referring Physician and fax them a letter explaining the services rendered and what is needed to submit an appeal to the Insurance Carrier. Once received, the appeal is submitted to the Insurance Carrier for review. If the Insurance carrier upholds their denial and the documents received from the Physician have a strong basis, we will apply for arbitration on behalf of the Hospital.

Arbitration Fees

Arbitration and Fees are paid directly by our Company. When the Arbitration is found in favor of the Hospital, payment of the claim, interest and the Arbitration fee which was paid in advance is processed to the Hospital (we will bill The Hospital for the Arbitration Fee at 100%, since we paid the money upfront).

New York State Department of Insurance

Any Insurance Carrier that does not comply with the N.Y.S. No-Fault Laws of submission of payment, or request for additional information, will be reported to the Department of Insurance, on a case-to-case or a batch basis. Since there is not exception to a claim submitted on the 46th day, there is no exception for any claim not paid within the time limitation.

Police Reports

Fees for obtaining a police report are paid by our Company.

Fee Scheduling

All accounts are Fee Scheduled prior to billing. Once payment is received from the Insurance Carrier, the account is checked for proper payment. In the event that payment is not made according to the N.Y.S. Fee Schedule, contact will be made with the Insurance Company to submit the claim for reprocessing.

Liens

In the event that the Insurance Carrier denies the entire claim or individual bill and there is an Attorney involved, we will file a lien on behalf of the hospital. An acknowledgement letter is requested on all liens filed.