Scope:

This policy applies to Prime Healthcare Service and its wholly owned subsidiaries and affiliates; and any healthcare facility or hospital in which Prime Healthcare Foundation owns a direct equity interest greater than 50% (Prime Entities).

Purpose:

To define the policy for billing and collection of account receivables and to manage facility patient account receivables in a manner to minimize the allowance of doubtful accounts and ensure reasonable collection efforts are administered. This is necessary to ensure proper accounting, handling, assignment, timely resolution, regulatory compliance, and proper write-off of bad debt accounts. This policy encompasses all patients, regardless of class, and assumes that any outstanding balances pursued are owed by the patient/beneficiary.

Definition:

Bad Debts: Claims arising from rendering healthcare services to patients who are unable or unwilling to pay their bills, and do not qualify for indigency/charity care programs. Accounts in "bad debt" status will be deemed worthless/uncollectible upon electronic health record ("EHR") system write off.

Addition: An Account may be advanced to bad debt after completion of the first party early out cycle of at least 90 days and all reasonable collection efforts have been exhausted.

Non-Indigent Medicare Beneficiary: A Medicare beneficiary who has not been determined to be categorically or medically needy by a State Medicaid Agency to receive assistance from Medicaid and has not been determined to be indigent by the provider for Medicare bad debt purposes. Refer to *42CFR Section 413.89 and PRM, Part 1 Chapter 3* for more information.

Original Medicare: Federal program that provides Medicare eligible individuals with coverage for health care services from providers who accept Medicare. Traditional Medicare plans provide health insurance benefits payable under Part A and Part B of the Title XVIII Medicare program

Medicare Advantage ("MA"): Private-sector health insurance coverage that provides Medicare benefits for inpatient and outpatient services, and commonly provides prescription drug coverage.

Self-Pay Patient: Patient who does not have third-party coverage from a health insurer, health care plan, Medicare or Medicaid, and whose injury is not a compensable injury, as determined and documented by the provider.

Early Out ("EO"): Initial vendor responsible for the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations.

Agency Placement: Accounts returned from EO vendor with a remaining patient liability will be placed with the contracted outside collection agency utilized to collect on accounts in "bad debt" status.

Medicare Bad Debt Recovery: Payment received on an amount that was previously claimed and paid as a Medicare bad debt, in a prior cost reporting period or a payment received in the current cost reporting period for bad debts claimed in the current cost reporting period.

PROCEDURES:

I. Billing & Collections

A. <u>Early Out ("EO") Vendor-</u> All accounts with a patient balance remaining after insurance adjudication, self-pay accounts (no identified responsible payer) and accounts that do not qualify for financial assistance, charity care or have not been determined to be categorically or medically needy, shall be deemed eligible for patient account billing. These accounts shall initially be outsourced to an ~~EO~~ external Early Out billing vendor within 90 days of the patient's discharge date, with the exception of accounts held in particular circumstances as outlined below (4b). The EO vendor is tasked with the following objectives:

1. Issue a bill to the responsible party for the patient's personal financial obligations on or shortly after discharge or death of the patient.

PROPOSED UPDATE:

A. Early Out ("EO") Vendor— All accounts with a patient balance remaining after insurance adjudication, self-pay accounts (no identified responsible payer) and accounts that do not qualify for financial assistance, charity care or have not been determined to be categorically or medically needy, shall be deemed eligible for patient account billing. These accounts shall initially be outsourced to an EO billing vendor within 90 days of the patient's discharge date, with the exception of accounts held in particular circumstances as outlined below (4b). The EO vendor is tasked with the following objectives:

   a. Issue a bill to the responsible party for the patient's personal financial obligations on or shortly after discharge or death of the patient. [1] CMS 2021 PPS Final Rule

[1] The CMS 2021 [PPS Final Rule clarifies and codifies Medicare bad debt regulations related to reasonable collection effort. Effective for cost reporting periods on or after October 1, 2020, providers must issue a bill to the beneficiary, or the responsible party, on or before 120 days after the latter of (1) the date of the final Medicare remittance advice that generates the beneficiary's cost sharing amounts {2) the date of the remit from the secondary payer, if any or (3) the date of the notification that the secondary payer does not cover the services furnished to the beneficiary.

regulation below requires providers to issue a bill to the beneficiary, or the responsible party, on or before 120 days of the date of the final remittance advice.

i. Insured patients: Less than 120 days from the last Insurance remittance

ii. UnInsured / True Self Pay patients: Less than 120 days from Final Bill date in the EHR.

2. Early Out vendor will generate, deliver, and maintain supporting documentation for subsequent billing statements, collection letters, reports of telephone calls, emails, text messages and personal contacts, etc. communicated to the responsible party. Early Out vendor will send back standardized notes into the hospital EHR system of record for documentation of collection efforts.

3. In cases where a secondary/tertiary insurance or payer is identified for a patient after placing the account with the EO vendor, the notified party will inform the account owner to place the account on hold. Depending on the facility and hospital system, if insurance is found to be valid, the account will be closed in the patient billing vendor's office. If a patient responsibility balance remains after insurance has been billed, the account will place with the EO vendor as a new assignment, effectively restarting the billing cycle.

PROPOSED Update:

1 The EO vendor will return accounts to the provider in cases where full payment or settlement has not been secured.

a. Early Out vendor may accept prompt-pay discounts settlements on the patient liability after Insurance payment of 10% of the Co-PAY or Co-insurance liability. Discounts are not to be offered on the patient deductible as deemed by the Insurance payer until. Prompt-pay discounts cannot be combined with a payment plan for the patient liability.

b. Settlement offers on patient liability for Uninsured patients can be processed by the Early Out vendor. Settlements are limited to 50% of the patient liability, any amount exceeding 50% of the patient liability require approval from the facility CFO.

c. Accounts in special situations, irrespective of class or type of payor, (including but not limited to: payment plans, disputes, research of required information, bankruptcy, probate, fraud, ID theft, rebilled/pending insurance or indigency status), shall be excluded from bad debt status/placement until such issues are resolved. All vendor relationships will allow for accounts to be recalled by the facility or business office at any time to address these cases on an individual basis.

d. The Early Out vendor will return the account when an account has been sent all applicable statements, calls and digital engagements. The Early Out vendor will identify the account has completed the Early Out revenue cycle. Accounts will be evaluated at the hospital for "bad debt" status and qualify for collection agency placement. Accounts with an Insurance balance must be resolved prior to Bad Debt placement, only Self pay balance should be placed with a bad debt agency.

e. The Hospital business office manager/director is responsible for the movement of an account to a bad debt collection agency.

(The CMS 2021 IPPS Final Rule clarifies and codifies Medicare bad debt regulations related to reasonable collection effort. Effective for cost reporting periods on or after October 1, 2020, providers must issue a bill to the beneficiary, or the responsible party, on or before 120 days after the latter of (1) the date of the final Medicare remittance advice that generates the beneficiary's cost sharing amounts (2) the date of the remit from the secondary payer, if any or(3) the date of the notification that the secondary payer does not cover the services furnished to the beneficiary).

Note: The Medicare program expects providers to refer all uncollected patient balances of like amount to collection agencies without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges in which amounts are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Accounts must also be recalled from collections in this same manner. All Prime Entities participating in the Medicare program shall meet this requirement without exception.

If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt is eligible to be deemed uncollectible. Any payment received restarts this 120-day clock. No accounts should be written-off in the EHR system until at least 120 days has elapsed since the last payment was received on an account.

B. Bad Debt Vendor Agency Placement

Accounts returned from EO vendor with a remaining patient liability will be evaluated for placement into a "bad debt" status and will be placed with the contracted external collection agency. An

account is in "bad debt" status, the account has not yet been deemed worthless and uncollectible since these accounts are designated for collection agency placement.

Prime may choose to use a Primary and Secondary vendor for Bad Debt.

1. Primary Vendor will receive the initial placement into Bad Debt status and work accounts from Day 0 through Day 180. Primary Vendor will return accounts that have been exhausted after 6 months and have not entered into a payment plan to resolve the patient liability.

2. Secondary Bad Debt Vendor will receive accounts at Day 181 and work account through Day 720. The after the Primary vendor has returned the account as uncollectable. Secondary vendor will work accounts for 18 months (540 days) to complete the 2 Year cycle for Bad Debt.

3. All collection effort is to be documented and maintained by the agency with copies of the billing statements, follow-up letters, reports of telephone calls, emails, text messages and personal contacts, etc. This information is obtainable from the collection agency upon request.

a. Once the external collection agency exhausts all avenues for collection or once two years (720 days) have elapsed from placement (whichever date is later), accounts will be recalled by the provider and written off in the EHR system utilizing the write-off procedures specified in this policy. At this time the account is deemed worthless and uncollectible. [3] Accounts enrolled in a payment plan at the two-year mark and account balances equal to or greater than $2,000 will remain at the external collection agency until the state Statute of Limitations expires, irrespective of class or payer type. Refer to Appendix A for individual state guidelines.

b. All collection effort will cease upon collection agency recall/return with no further action pursued internally or by the agency. This is to be evidenced by an agency closeout report or written confirmation from the collection agency, which shall be retained as supporting documentation. This closeout report should include the patient account number, date and amount received, the date and amount returned, and all payments collected, at minimum.

c. In the case of an International Guarantor where the patient is a foreign resident and/or possessed foreign insurance, unpaid patient balances will be outsourced to a separate international vendor for billing purposes. This will occur upon identification of such an account, whether this be prior to or during EO or collection agency placement. If already placed with an EO or collection agency vendor, the appropriate vendor will be notified to close out and return the account prior to placing with the international vendor. Such accounts will remain with the international vendor until payments cease to be received, or after two years, whichever date is

later. At that time, the account will be closed with the international vendor and written off according to the established write-off procedures as "International — Uncollectible."

i. Write off after 2 years of an International Guarantor is processed using the International Iplan in the host system as an Adjustment.

Financial Assistance applications will be accepted at any point in the revenue cycle. Financial assistance documents are available to patients / guarantors on the hospital's website. Both Early Out and Bad Debt vendors will assist any patient / guarantor with obtaining a copy of the hospital financial assistance documents. The Hospital Financial Assistance phone number is included in the statements printed by both Early out and Bad debt vendors.

Any information obtained from income tax returns, paystubs, or the monetary asset documentation collected for the discount payment or charity care eligibility determinations or financial assistance is not provided to Bad Debt collection agency for use in collection activities.

C. Write-Off Procedures

1. Once an account is recalled by the Prime Entity and/or returned unpaid from the external collection agency, all collection effort shall cease. The debt should be deemed worthless and written-off in the EHR system, resulting in a zero-patient balance after insurance adjudication. A determination should be made prior to write-off to ensure no payments have been received on the account in the preceding 120-day period. Accounts should not be written off until at least 120 days has passed from receipt of the most recent payment.

2. Only bad debt transfers or write-off transactions should be processed through bad debt allowance codes within the billing system, (e.g., charity write offs should be adjusted with a contractual allowance adjustment code, rather than a bad debt adjustment code, or transferred to "bad debt" status).

   i. On the GL side, bad debt write offs should be processed through the allowance account (01 account 110410-0000) and expense account

(580000000), including primary self-pay balances, and patient balances after insurance adjudication. Dual- eligible bad debt must be written off to a bad debt expense adjustment code (580000000.404306-0004 {IP} or 580000000.444306-0004 {OP}). Medicare Traditional Self Pay bad debt must be written off to a bad debt expense adjustment code (580000000.404306- 0005 {IP} or 580000000.444306-0004 {OP}).

ii. At the end of the fiscal year, Corporate Finance will capture any Medicare Bad Debts incorrectly classified as contractual allowances and perform an entry on the GL to reclassify these amounts to bad debt expense. Effective 10/1/2020, all Medicare bad debt must be recorded as a component of net patient revenue and must not be written off to a contractual allowance account but must be charged to an uncollectible receivables account that results in a reduction in revenue (implicit price concession), per CMS 2021 IPPS Final Rule (also refer to revenue recognition standards from FASS Accounting Standards Update Topic 606, Revenue from Contracts with Customers).

3. In many situations, EO or collection agencies send payments via a remittance, which may or may not reflect the collections from patients on a gross basis (before applying commissions). The cash collection on accounts written off must be recorded on a gross basis (prior to deduction of collection fee) within the patient account in the billing system and credited to Provision for Bad Debt (01 account 580000000-XXXXXX). Recoveries should not be recorded on the balance sheet. The collection fee should be charged to collection fee expense (expense sub-account 665500).

4. All bad debts will be net of any payments received from the beneficiary or other third-party payers. When a beneficiary, or a third party on behalf of the beneficiary, makes a partial payment of an amount due to the provider, which is not specifically identified as to which debt it is intended to satisfy, the payment is to be applied proportionately to the different categories of deductibles and coinsurances, such as inpatient, outpatient or non-covered. The basis for pro-ration of partial payments is the proportionate amount of "amounts owed" in each of these categories.

Note: Any special deviations from the above procedures should first be discussed with the Patients Account Manager, Business Office Manager, Corporate Finance team or Outsourcing & Strategic Initiatives (OSI) team.

D. Other Financial Arrangements

A. If at any time during the course of reasonable collection effort, it is determined that a patient is indigent or medically indigent and unable to pay their outstanding debt, a financial assistance application should be provided to the patient for completion. Refer to separate charity care or indigency program policies for additional information.

B. Medicare/Medicaid dual eligible patient accounts do not require beneficiary collection *effort* and must be charged to an uncollectible receivables account that results in a reduction in revenue (contractual allowance write-off is not allowable in order to receive Medicare bad debt reimbursement). These dual-eligible Medicare bad debts can be written *off* upon receipt of a valid Medicaid remittance advice. When a State does not process a Medicare crossover claim and issue a Medicaid remittance advice, the following documentation should be maintained:

1. State Medicaid notification evidencing lack of obligation or notification of the

provider's inability to enroll

2. Documentation setting forth the State's liability, or lack thereof, for the Medicare cost sharing
3. Documentation verifying the beneficiary's eligibility for Medicaid for the date of service.

C. In particular circumstances (e.g., COVID-19 pandemic), Prime Entities have the option to discount deductible/coinsurance amounts or waive deductibles/coinsurance under an approved waiver program. For Medicare beneficiaries, CMS guidelines currently require these Medicare bad debt claims to be excluded from the Medicare bad debt listing referenced in Appendix B.

POLICY:

A. Prime Entities shall use only corporate agency contracts for patient billing collections. Contracts for nonprofit hospitals must require external agencies to comply with Section 501 (r) requirements regarding extraordinary collections actions.

B. The Business Office Director/Manager shall complete monthly inventory reconciliations with the Early Out and Bad Debt collection agency vendors.

C. Small balance write-offs are permitted on the monthly inventory for accounts with balances below $10.

D. Bankruptcy

- All bankruptcy notifications received by the facility will be shared with the appropriate patient billing vendor immediately (upon receipt).
- Upon notification of a Chapter 13 bankruptcy filing, the patient billing vendor holding

the account will file claims for all accounts with balances equal to or exceeding $100, with the exception of specific California providers.[4] Chapter 7 bankruptcy filings dismissals or discharges are to be returned and written off in the EHR system as "bankrupt - uncollectible" since no further action will be taken (account deemed worthless). In general, balances should not be adjusted or written off while the account is in "bad debt" status. However, a write-off is allowable upon verifying the account has been deemed worthless (no further collection effort or options).

Note: Bankruptcy balances for Medicare beneficiaries should be included on the Medicare bad debt listing filed with the annual Medicare cost report (see Appendix B), provided supporting documentation from the court is on hand or easily accessible. Identified Insurance/Workers Comp ("WC")/Third-Party Liability ('TPL")/Charity Applications

- Upon discovery that insurance requires research/billing for an unpaid account, the patient billing vendor will advise the business office (or vice versa) and the patient billing vendor will put the account on hold. Depending on the facility and hospital system, if insurance is found to be valid, the account will be closed in the patient billing vendor's office. If a patient responsibility balance remains after insurance has been billed, the account will place with the EO vendor as a new assignment, effectively restarting the billing cycle.
- If WC or TPL is identified on an account, the patient billing vendor will return the account, noting appropriately. The business office will redirect the account to the appropriate work queue.

[4] *There are specific vendors that do not pursue Chapter 13 balances based on unique contractual arrangements. California providers should consult with the Corporate Finance team to gain an understanding of their vendor agreement and seek guidance, as needed.*

- If a financial assistance application is received and indigency/charity eligibility efforts begin, the patient billing vendor will be notified by the business office. Refer to separate charity care or indigency program policies for more information.
  - Elective procedures that are not medically necessary will not be eligible for financial assistance.
  - Definition for Medical Necessity: Hospital services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine, including services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

E. Revoked Insurance

Regardless of where an account is in the revenue cycle, if insurance is deemed invalid and the account flips to a self-pay status, any and all self-pay discounts that would have been available to the patient at initial time of assignment (as a self-pay account) should apply. The account will be reprocessed with any prior discounts applied. The current vendor responsible for the account will resume the billing process.

F. **Timely Filing Issues**

If insurance is not billed in a timely manner:

a). The insurance balance due may not transfer to a patient responsibility balance ii. Prime is still able to pursue the patient for their patient responsibility.

b). Contractual adjustments should be applied and patient responsibility is updated based upon the Insurance remittance.

G. **Payment Plans/Settlements**

1) Vendors are authorized to establish payment plans and other settlements with guarantors in accordance with established direction from the business office. Changes to initially provided guidelines must route through outsourcing for adherence to any regulatory requirements regarding pricing. Exceptions require CFO approval.

H. **Prime Employees**

1. No employee discounts are available.
2. Bad Debt assignment
   a) Employee accounts with Keenan coverage and eligible for bad debt assignment should be reviewed for proper charges.
   b) If charges do not appear to be applied properly, the EHP team should be contacted for claim validation and/or review of incorrect processing of claims at EHPClaimDepartment@PrimeHealthcare.com

c) In cases where a Prime employee enters "bad debt" status, standard bad debt billing and collection procedures should be followed.

I. Deceased Guarantors

Upon notification to the facility or vendor of a guarantor's passing, the account will be placed on hold until notification of probate opening. Once the determination is made that the related account balance exceeds the specified threshold established with the individual vendor, the vendor will follow prescribed steps to enforce a claim against the decedent's estate. The state having jurisdiction over the decedent's estate sets those procedures. These accounts will be deemed uncollectible and shall be returned by the vendor upon settlement of the estate or verification that no estate exists and subsequently written *off* in the EHR system as "Deceased - Uncollectible." If no estate documentation is obtained, the account should be written-off two years after the date of death.".

Note: Deceased Medicare beneficiaries should be included on the non-indigent Medicare bad debt listing (see Appendix B), provided probate documentation is accessible to support the account is fully uncollectible.

J. Credit Bureau Reporting and Extraordinary Collection Activities

1) Prime authorizes vendors following regulations to report to the credit bureau(s) no sooner than 180 days after the date of assignment to the bad debt vendor, provided all contracted billing and collection steps have been followed. The account must meet the following requirements:

a) Have a balance greater than $50

b) Have a charity score greater than 1500 (greater than 150% of the federal poverty guideline)

c) The consumer does not reside in CA, CT, MA, ME, RI, TX, WA, or UT (see comment

text).

d) The social security number is not missing

e) The consumer is 21 years of age or older

f) The date of delinquency (from date of discharge) must be greater than 180 days (for- profit), or greater than 300 days for non-profit providers

g) The account is not in a payment plan, dispute, or held disposition

h) No payments have been received on the account within the past 90 days

2) Legal efforts (e.g., wage garnishment, liens, and judgements) are allowable if:

a) Account has a minimum balance of $1,500

b) Guarantor appears to have ability to pay but is unwilling to do so (depending on guarantor location, the credit score may be used as a determining factor)

c) All other efforts are exhausted

d) A valid place of employment for the consumer is confirmed with gainful employment of over two years.

APPENDIX A – Statute of Limitations

Purpose

The purpose of this document is intended to gain an understanding of the statute of limitations on debt collection as well as understanding their influence on how they affect patient liability collection efforts. Additionally, this document is to provide a procedure for the handling of account balances being evaluated for release of a patient liability balance for Early Out and Bad Debt collection efforts.

Procedure

The statute of limitations for debt is the period of time that a debt can be legally enforceable. For HBSI, the statute of limitations for debt collection must be considered when releasing remaining patient responsibility for collection efforts b•, our Early Out and Bad Debt vendors.

Accounts being considered for release to a Prime vendor for the collection of a remaining patient liability should be evaluated for the state of residence and corresponding statute time limit as well as the length of time since the most recent account resolution activity to ensure the account qualifies.

MOST RECENT ACCOUNT RESOLUTION ACTIVITY

Because the statute of limitations makes the collection of outstanding debt time bound, understanding the date on which the most recent account activity occurred is particularly important. When assessing if a balance is still within the statute time limit, the account should be evaluated for the following activity.

1. **The date of the EOB-** if the patient has insurance coverage, the date of the EOB where the insurance has assigned the remaining balance to patient responsibility can be used as the first day of the statute time limit.

2. **The date of the last patient payment-**The date of the last patient payment can be used as the first day of the statute time limit.
3. **The date of service-** If there has been no insurance payment activity nor any patient payments, the date of service should be used as the first day of the statute time limit.

STATE OF PATIENTS RESIDENCE

All 50 states and the District of Columbia have their own statue, it is important to consider the patients state of residence on the date of service. It is this the state's statute of the patient's resident that would apply to collection of any remaining patient liability.

Current law stipulates that healthcare balances must be billed to the guarantor within 11 months from date of visit.

Reference the table below to the applicable state statute of limitations:

State	Statute of limitations for Debt Collection
Alabama	6 years
Alaska	3 years
Arizona	6 years

Arkansas	5 years
California	4 Years
Colorado	3 Years
Connecticut	6 Years
Delaware	3 years
Washington DC	3 Years
Florida	5 years
Georgia	6 years
Hawaii	6 years
Idaho	5 years
Illinois	10 years
Indiana	6 years
Iowa	10 years
Kansas	5 years
Kentucky	15 years
Louisiana	10 years
Maine	6 years
Maryland	3 Years
Massachusetts	6 years
Michigan	6 years
Minnesota	6 years
Mississippi	3 years

Missouri	10 years
Montana	8 years
Nebraska	5 years
Nevada	6 years
New Hampshire	3 years
New Jersey	6 years
New Mexico	6 years
New York	6 years
North Carolina	3 years
North Dakota	6 years
Ohio	8 years
Oklahoma	5 years
Oregon	6 years
Pennsylvania	4 years
Rhode Island	10 years
South Dakota	6 years
Tennessee	6 years
Texas	4 years
Utah	6 years
Vermont	6 years
Virginia	5 years
Washington	6 years

West Virginia	10 years
Wisconsin	6 years
Wyoming	10 years

ACCOUNTS OUTSIDE OF THE STATUTE TIME FRAME

Account balance should be evaluated during each step of the patient collection process, meaning that accounts returning from the Early Out Collections vendor should be reevaluated before placement to Bad Debt. All time frame and statute information would apply to accounts being considered for Bad Debt placement.

Should an account fall outside of the statute of limitations for the patient's state of residence, the balance of the account can no longer be collected and would need to be adjusted to a zero balance. All current procedures for requesting a balance adjustment in the facility host system should be followed. Additionally, the account should be documented with the reason for the adjustment request.

Example: REMAINING ACCOUNT BALANCE OF $XX, XX IS PATIENT RESPONSIBILITY. ADJUSTMENT FOR THE ENTIRE BALANCE IS BEING REQUESTED AS THE BALANCE IS OUTSIDE OF THE STATUTE Of LIMITATIONS FOR THE PATIENTS STATE OF RESIDENCE BASED UPON THE LAST RESOLUTION ACTIVITY DATE OF XX/XX/20XX.

Should you have any additional questions regarding the handling of accounts based on the above outlined process, please see a member of your leadership team.

APPENDIX 8 – Medicare Bad debt reporting

Claims for Medicare bad debt reimbursement are made through the annual Medicare cost report. All Prime Entity Medicare participating providers that are eligible to claim reimbursement for unpaid Medicare Part A and/or Part B deductibles and coinsurance shall have processes, procedures, and controls designed to:

- Identify all unpaid Medicare deductibles and coinsurance that satisfy the requirements to be claimed as a Medicare bad debt.
- Ensure that the billing and collection requirements established by CMS that pertain to Medicare bad debts are satisfied; and
- Accumulate and preserve the required information and evidence of collection effort prior to any claim for Medicare bad debt reimbursement being submitted for reimbursement

Refer to 42 *CFR Section 413.89* and the *Medicare Provider Reimbursement Manual(PRM, Part I, Chapter 3)*

Final versions of the Medicare bad debt listings should be compiled using the below CMS Exhibit 2A format, effective for cost reporting periods beginning on or after 10//1/2020. Bad debt should be claimed net of all recoveries and payments received. The bad debt listings should be separated by type:

- Three types of Medicare bad debt
  - Non-Indigent
  - Dual Eligible Indigent
  - Non-Dual Eligible Indigent
- Separate inpatient/outpatient/subunits. Submit a separate log for each of these.

DRAFT FORM CMS-2552-10 4004.2

EXHIBIT 2A

LISTING OF MEDICARE BAD DEBTS

PROVIDER NAME: _____ *CCN:* _____ *FYE:* _____ *PREPARED BY:* _____

BAD DEBTS FOR (CHOOSE ONE): ___ *INPATIENT* ___ *OUTPATIENT* *DATE PREPARED:* _____

CLAIM TYPE (CHOOSE ONE): ___ *NON-DUALLY ELIGIBLE* ___ *DUALLY ELIGIBLE/CROSSOVER*

MEDICARE BENEFICIARY													
BENEFICIARY NAME		*MBI OR HICN*	*PATIENT ACCT. NO.*	*DATES OF SERVICE*		*MEDICAID NO.*	*DEEMED INDIGENT*	*REMITTANCE ADVICE DATE*		*SECON. PAYER REMIT. ADV. REC'D DATE*	*BENEFICIARY RESPONSIBILITY AMT.*	*DATE FIRST BILL SENT TO BENE.*	*A/R WRITE OFF DATE*
LAST	*FIRST*			*FROM*	*TO*			*MEDICARE*	*MEDICAID*				
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*
TOTAL													

LISTING OF MEDICARE BAD DEBTS (CONT.)											
COLLECTION AGENCY INFORMATION		*COLLECT. EFFT. CEASE DATE*	*MEDICARE WRITE OFF DATE*	*RECOVERIES ONLY*		*MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS**		*CURRENT YEAR PAYMENTS RECEIVED*		*ALLOWABLE BAD DEBTS*	*COMMENTS*
SENT (Y/N)	*RETURN DATE*			*AMOUNT RECEIVED*	*MCR FYE DATE*	*DEDUCT.*	*COINS.*	*AMOUNT*	*SOURCE*		
15a	*15*	*16*	*17*	*18*	*19*	*20*	*21*	*22*	*23*	*24*	*25*
TOTAL											

* *Report deductible and coinsurance amounts only when the provider billed the patient with the expectation of payment. See column 8 instructions for possible exception.*

(Cont.)

APPENDIX B – Medicare Bad Debt Reporting

The Prime Entities shall, without exception, adhere to all of the following in the identification, reporting of and accounting for Medicare bad debts:

1. Generally, Medicare bad debt must meet all of the following criteria to be allowable:
   a) The debt must be related to covered services and derived from deductible and coinsurance amounts.
   b) The provider must be able to establish that reasonable collection efforts were made.
   c) The debt was actually uncollectible when claimed as worthless.
   d) Sound business judgment established that there was no likelihood of recovery at any time in the future,
2. The bad debt must not relate to physician professional services and noncovered services.
3. Collection effort must be the same for all payers.

Note: Medicare bad debt excludes Medicare advantage, unpaid Medicare premiums and copayments, any covered services paid under a contractual capitated rate-based plan, non-covered service items, amounts related to physician services paid on a fee schedule, non-Medicare recipients, non-Medicare contracted providers (non-certified subunits), charity allowances, charity care and presumptive charity (use of sliding scale or credit scoring system alone is

insufficient).

The below checklist should be utilized to assist in submitting an accurate Medicare bad debt listing. It is recommended all steps on the below checklist be performed prior to cost report submission.

Basic Log Testing Procedures - Checklist

- Perform a search for duplicates. Include accounts from prior year submission.
- Ensure all write-off dates fall within the current cost reporting period.
- Calculate to verify bad debt does not exceed total deductible + coinsurance.
- Foot the bad debt listing (include a summary).
- Confirm fillCMS required information is included.
- Perform the following calculations on the non-indigent Medicare bad debt listings:
    - Timely Billing: Patients should be billed on or shortly after discharge. Refer to Procedure 1.A.1 to determine billing thresholds.
    - 120 Day Rule: Accounts should not be written off until at least 120 days after the patient's first bill date. Note than any payment resets the 120- day rule clock.