MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

BAD DEBT COLLECTION POLICY

POLICY:

To ensure the follow-up for all private pay accounts is adequately and appropriately performed in a timely manner. To also ensure that bad dept accounts are appropriately referred to collection agencies or adjusted as write-offs.

PROCEDURE:

The most current version of the Fair Debt Collection Practices Act will be followed when attempting to collect from patients.

Mayers can only demand payment up to what Medicare or Medi-Cal would pay (whichever is greater) for patients eligible for discounted care.

The following processes must be followed prior to sending a patients account to a bad dept collection agency:

1. At least three (3) statements and one payment request letter will be sent. One (1) from Mayers, at least (2) from AR Services.
2. At least one (1) phone call attempt will be made by AR Services.
3. At least one collection notice will be sent containing the following information:
    a. The date or dates of service of the bill that is being assigned to collections or sold;
    b. The name of the entity the bill is being assigned or sold to;
    c. An itemized statement will be sent to the patient with the letter that includes the name and type of health plan coverage on record for the patient at the time of service or a letter stating the hospital did not have this information;
    d. An application for the hospital's charity care and financial assistance;
    e. The date or dates the patient was originally sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and , if applicable, the date a decision on the application was made.
4. The patient's account must be overdue by at least 180 days from the first statement or letter date.

5. Should the patient only have one account in the system under $24.99, the account will be written off as a small balance.
6. The hospital will forgo garnishment of wages, liens on a primary residence, applying interest to debt, adverse credit reporting, or filing a lawsuit. If this occurs, it will be performed by A1 Collections after the agency confirms that the patient is able to pay but not willing to do so.

BILLING DISPUTES:

1. If at any time prior to sending the account to bad debt, the patient does not agree with the charges, the charges will be reviewed by the Business Office Manager, and/or the Health Information Manager for accuracy.
2. If changes are required, the patient will be notified and the charges will be re-billed to the insurance company, if applicable. If the patient does not have insurance a new bill will be sent directly to the patient.
3. If the patient still does not agree with the findings, it will be forwarded to the Quality Director.

CONTRACTED COLLECTION AGENCY:

MMHD will ensure the following when contracting with a collection agency.

1. Include contractual language in which the collection agency agrees to abide by all fair debt collection laws.
2. Include contractual language in which the collection agency agrees to meet key components of this collection policy as well as any legal requirement that would apply if action were taken directly by the hospital.
3. Include in contractual language in which the collection agency agrees to send attestation of compliance with the hospital's bad debt policies and obligations.
4. Lawsuits recommended by agency may be initiated only through express written authorization of the Chief Executive Officer and in compliance of this policy.
5. The collection agency will forgo garnishment of wages, liens on primary residence, applying interest to debt, adverse credit reporting, or filing a lawsuit unless the collection agency has established that the individual is able but not willing to pay.
6. Obtain a HIPAA Business Associate Agreement.

CONTRACTED DEBT BUYER:

MMHD will ensure the following when contracting with a debt buyer.

1. Include contractual language in which the debt buyer agrees to abide by all fair debt collection laws.
2. Include contractual language in which the debt buyer agrees to meet key components of this collection policy as well as any legal requirements that would apply if action were taken directly by the hospital.
3. Include in contractual language in which the debt buyer agrees to send attestation of compliance with the hospital's bad debt policies and obligations.
4. Lawsuits recommended by debt buyer may be initiated only through express written authorization of the Chief Executive Officer and in compliance of this policy.
5. The debt buyer will forgo garnishment of wages, liens on primary residence, applying interest to debt, adverse credit reporting, or filing a lawsuit unless the collection agency has established that the individual is able but not willing to pay.
6. Obtain a HIPAA Business Associate Agreement.
7. Include contractual language in the sales agreement in which the debt buyer agrees to return and the hospital agrees to accept any account in which the balance has been determined to be incorrect dure to the availability of the third-party payer, including a health plan or government health coverage program, or the patient is eligible for charity care of financial assistance.
8. Include in the contract that the debt buyer is licensed by the Department of Financial Protection and Innovation.

ADJUSTMENTS:

Medi-Cal or Partnership Healthplan accounts which receive inpatient, or outpatient cutback adjustments will be written off as Inpatient or Outpatient Cutback adjustments. A list of these accounts will be sent to the person responsible for cost reporting, upon request.

WRITE-OFF APPROVALS:

The write-offs below must have the approval Chief Financial Officer.

1. No Certification: When pre-certification is required by the insurance company but not obtained by Mayers Memorial Healthcare District (MMHD) the charges are written off after a denial is received from the insurance company.

2. Un-authorized Days: When a patient stays at MMHD as an inpatient beyond the authorized days the charges are written off after a denial is received from the insurance company.
3. Discount: A discount can be negotiated between the patient and the Financial Counselor. If the write off is more than 25% of the balance, the financial counselor will first get approval from the Business Office Manager or the Chief Financial Officer.
4. Timely Filing: When the insurance company had denied a claim after appealing.
5. Any write-offs over $500.00, other than inpatient and outpatient adjustments and other normal adjustments listed on the remittance advice