



Saint Agnes Medical Center

EFFECTIVE DATE:
April 1, 2025

PROCEDURE TITLE:

Bad Debt Policy

PURPOSE

The purpose of this policy is to define how patient bad debt accounts are identified and handled for Saint Agnes Medical Center.

PROCEDURE

Guarantor accounts with unpaid balances, where a patient has been determined to be ineligible for financial assistance or without response to any bill attempts or offers for Financial Assistance for 180 days, are considered bad debt. After all aspects of this procedure are applied and reasonable collection efforts are taken, the local Chief Financial Officer may transfer the account to an external collection agency, or refer for legal action.

- I. Qualifications for Bad Debt Review:
 - A. If an account has an unpaid balance that is greater than 180 days from the patient's first post-discharge Billing Statement, and is less than \$10,000, and:
 1. If the patient is uninsured, the account will be scored using a predictive tool to determine eligibility for presumptive support (i.e., financial assistance).
 - a. If qualified for 100% presumptive support, the account balance is reduced to zero and a letter is sent to the patient.
 - b. If qualified for partial presumptive support, the account balance is reduced by the appropriate discount; a letter with the new adjusted balance is sent to the patient along with instructions on how to be considered for more generous support; and the account is then transferred to an external collection agency.
 - c. If patient does not qualify for presumptive support, it will be transferred to an external collection agency.
 2. If the patient is insured, the account will be transferred to an external collection agency.
 - B. Physician services accounts with a balance less than \$1,000 are reviewed for bad debt criteria and manually sent to an external collection agency without presumptive support review.
 - C. If the account has an unpaid balance that is greater than 180 days from the patient's first post-discharge Billing Statement, and is \$10,000 or greater:

1. The account will appear on a report that is forwarded to a Financial Assistance Representative.
 - a. The Representative will verify that services are medically necessary.
 - b. If services are medically necessary, the Representative will verify that all payer resources (e.g., Medicaid, county indigent programs, commercial insurance, liability insurance, Crime Victim funds, worker's compensation, etc.) have been exhausted.
 - i. If payer resources have not been exhausted, the Representative will determine whether a claim needs to be sent back to billing
 - ii. If payer resources have been billed and the claim processed as in-network, leaving the balance as patient responsibility, the account will be reviewed for presumptive support.
 - iii. If payer resources have been denied due to non-cooperation from the patient or the services are out-of-network, the account will be transferred to a collection agency.
 - c. If the account qualifies for presumptive review, the Representative will review for presumptive support qualifiers (e.g., homeless, food stamp recipient, deceased with no spouse and/or estate, member of religious organization with vows of poverty). If no qualifier is found, the Representative will use a predictive tool to determine eligibility for presumptive support.
 - i. If qualified for 100% presumptive support, the Representative will complete a Presumptive financial assistance request and obtain the appropriate approvals (see Approval Levels below). Once approved, the balance is reduced to zero and a letter is sent to the patient.
 - ii. If qualified for partial presumptive support, the Representative will complete a Presumptive financial assistance request and obtain the appropriate approvals (see Approval Levels below). Once approved, the account balance is reduced by the appropriate discount; a letter with the new adjusted balance is sent to the patient along with instructions on how to be considered for more generous support; and the account is transferred to a collection agency.
 - d. If the account does not qualify for presumptive review, the Representative will complete a Bad Debt request and obtain the appropriate approvals (see Approval Levels below). Once approved, the account is transferred to a collection agency.
- D. Information collected for discount payment or charity care determinations (i.e. income tax returns and paystubs) will not be used for collection activities.

II. Accounts in Collections

- A. A patient with an account that gets transferred to a collection agency will receive their first statement showing the referring hospital; balance owing and information regarding the hospital's financial assistance program.
 1. Accounts may be eligible for financial assistance. If financial assistance is granted, measures will be taken to reverse any credit reports related to amounts no longer owed by the patient.
 2. Accounts with balances not paid within 180 days can be transferred to a

secondary collection agency.

3. Legal action may be pursued for individuals who have the means to pay but do not pay or are unwilling to pay. Appropriate approval must be obtained by the functional leader for Patient Financial Services prior to commencing a legal proceeding or proceeding with a legal action to collect a judgment (i.e., garnishment of wages, debtor's exam).
4. Actions against the debtor's person, such as arrest warrants or "body attachments" will not be pursued.
5. The hospital reserves the right to discontinue collection actions at any time with respect to any specific account.

**Trinity Health
West Region Shared Service Center
Approval Levels for
Financial Assistance and Bad Debt**

<u>Level of Adjustment</u>	<u>Position</u>
Up to \$4,999	Staff
\$5,000- \$9,999	Team Lead
\$10,000-\$14,999	SSC Manager
\$15,000-\$24,999	Regional Manager, Patient Accounting
\$25,000-\$49,999	Regional Director, PFS
\$50,000-\$74,999	VP, Finance
\$75,000 & over	CFO

*** Presumptive Support adjustments, as determined via the automated predictive model will be processed via an automated process. Amounts up to \$9,999.99 will not require signed approval to further support the automated process.**