POLICY AND PROCEDURE

DEPARTMENT: Patient Financial Services Physician & SBO, Revenue Cycle		DATE ORIGINAL EFFECTIVE:
TITLE: Bad Debt Policy		DATE REVISION APPROVED: 08/02/2022
VERSION NUMBER: 2	Regulatory Standard #:	DATE OF LAST REVIEW: 10/26/2023
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PURPOSE:

It is the policy of Barton Healthcare System (BHS) to ensure that debts owed by patients for medical care delivered are collected in a timely manner. Payment for such debts will be pursued according to uniform criteria and procedures applicable to all BHS patients who have not qualified for Barton Healthcare System Financial Assistance Program (FAP).

POLICY:

It is the policy of Barton Healthcare System to bill patients and applicable third party payers accurately, timely, and consistent with applicable laws and regulations, including with limitation to the California Health and Safety Code section 127400 and regulations issued by the United States Department of the Treasury under section 501(r) of the Internal Revenue Code.

If, after reasonable and customary attempts to collect a patient balance as listed under "SELF-PAY BALANCE BILLING CYCLE" section of this policy, the patient's balance deemed debt remains unpaid and the patient has not qualified for financial assistance as per the criteria in the BHS Financial Assistance Program, the account may be referred to an external collection agency if the balance is $10.00 or more for physician bills and $20.00 or more for hospital bills.

The patient will be given a 10 day pre-collection notification sent by USPS that an account will be sent to an external collection agency. During the 10 day period the patient has the option of setting up a payment plan with BHS Customer Service representative to keep the account from going to the external collection agency.

The external collection agency will follow all guidelines set by Barton Healthcare System and remain compliant to all Federal and State regulations (i.e. State of California Health and Safety Code and IRS 501(r)). For patients that have been identified as having the ability to pay, regardless of payer source, the external collection agency will pursue and document collection efforts. Accounts that are deemed uncollectable will be returned back to Barton Healthcare System regardless of payer source, no sooner than 180 days from the time the

account was placed with the external collection agency.

SELF-PAY BALANCE BILLING CYCLE PROCESS:

Patients will be billed for their liability after all efforts to bill third party payers have been exhausted and it has been determined to the best of Customer Service Departments knowledge that the patient/guarantor is not covered by any type of coverage for services rendered.

If during the self-pay billing cycle the patient/guarantor expresses an inability to pay in full, Barton Healthcare System Customer Service Department will discuss other options that may be available.
Before an account is sent to an external collection agency, the patient will be sent the following correspondence regarding their account balance:

1. 1st self-pay statement is sent USPS 24 hours after an account has been deemed self-pay or in the next guarantor statement cycle
2. 2nd self-pay statement is sent USPS 28 days after the first self-pay statement
3. After the 2nd statement, patient receives an IVR balance reminder call
4. 3rd self-pay statement is send USPS 28 days after the second self-pay statement
5. Pre-collection notification letter is sent USPS 15 days after the third self-pay statement
6. Account is sent to an external collection agency 15 days after the pre-collection letter is sent

The statement process timing is based on no response from the patient/guarantor between self-pay statements and letter.

If sufficient payment, payment in full has not been received or a payment plan has not been established by the time the pre-collection notification letter is sent to the patient/guarantor, the account may qualify for placement to an external collection agency.

Accounts that qualify to be sent to an External Collection Agency

1. Insufficient or no payment has been received towards patient's account
2. Documentation that the patient has refused to make payment or set up a payment plan
3. Payment plan obligations have not been met
4. All contact attempts by Barton Healthcare System Customer Service department have been unsuccessful
5. Six month history of uncollectable accounts

All accounts are reviewed by the Customer Service Representatives before being sent to an external collection agency to ensure all criteria has been met. All actions taken with an account that does qualify to be sent to an external collection agency are documented.

MEDICARE BAD DEBT:

1. Costs attributable to the deductible and coinsurance amounts owed by Medicare beneficiaries that remain unpaid are added to the Medicare share of allowable costs and are reimbursed under the federal Medicare program. Costs attributable to the deductible and coinsurance amounts owed by Medicare beneficiaries for non-covered services provided are not allowable costs for purposed of Medicare reporting.

2. Definitions:
    1. Bad Debt: Bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing healthcare services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services and are collectible in money in the relatively near future

    2. Allowable Bad Debt: Allowable bad debts are bad debts resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 3-3 below. Allowable bad debts must relate to specific deductibles and coinsurance amounts.

    3. Deductibles and Coinsurance: Deductibles and coinsurance are amounts payable by Medicare beneficiaries for covered medical services.

    4. Dual Eligible Beneficiary: A patient who qualifies for both Medicare Part A and/or B and Medicaid coverage (e.g. Medi-Cal).

3. Criteria for Allowable Bad Debt:
    1. Under the federal Medicare program, costs of covered services furnished to Medicare beneficiaries are not to be borne by individual not covered by the Medicare program. Conversely, the costs of services provided for non-Medicare beneficiaries are not be borne by the Medicare program.

    2. In determining whether unrecovered costs of covered services are due to bad debts, the Medicare program is considered as a whole without distinction between Part A and Part B.

    3. A Medicare bad debt must meet 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 worthless

        d. Sound business judgment established that there was no likelihood of recovery at any time in the future.

4. Dual Eligible, Indigent and Medically Indigent Patients:
    1. Before discharge, or within a reasonable time before admission, it should be established whether a patient is indigent or medically indigent. A Dual

Eligible Beneficiary can be deemed indigent or medically indigent when such individual has been determined eligible for Medicaid as either categorically needy or medically needy. Barton Healthcare System's customary methods for determining the indigence of patients should be applied by the BHS Financial Assistance Program criteria.

2. Once indigence is determined and there has been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without having to pursue reasonable collection efforts, including sending the debt to a collection agency.
3. In the case of dual eligible patients who are deemed indigent under above section 4.1, any portion of patient responsibility not covered by the state Medicaid (Medi-Cal) program or any other welfare program are deemed uncollectible without having to pursue reasonable collection efforts, including sending the debt to a collection agency. However, the state Medicaid (Medi-Cal) program must be billed and the hospital must receive a Remittance Advice before the uncovered portion can be written off and claimed as bad debt.

5. Charging of Bad Debts and Bad Debt Recoveries:

The amounts uncollectible from Medicare beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. Allowable bad debts must be related to specific amount which has been determined to be uncollectible. Since bad debts are uncollectible accounts receivable and notes receivable, Barton Healthcare System will maintain the usual accounts receivable records and source documents to support its claim for a bad debt for each account included. In some cases an amount previously written off as a bad debt and allocated to the Medicare program may be recovered in a subsequent account period. Subsequent recoveries on amounts previously claimed as a bad debt are offset against total bad debts in the period collected.

6. After an account is return from the external collection agency:

All collection efforts will cease, accounts will be noted as written off and remain in Medicare bad debt status within Barton Healthcare System.

ALL OTHER BAD DEBT:

"Other Debt" is deemed not related to any service covered by Medicare.

After an account is returned from a collection agency, all collection efforts will cease, accounts will be noted as written off and remain in bad debt status within Barton Healthcare System.

SOURCES:

California Health and Safety Code Section 127400
IRC billing and collection practices 501(r) (3)

Medicare Financial Management Manual 100-06 Chapter 4
California Hospital Compliance Manual Chapter 5 & 8