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Owner: Debbie Kramer

VP Revenue Cycle Management

Area: Business Office

Applicability: Acadia System Wide Policies

Collections

SCOPE

Acadia Healthcare Co., Inc. (Acadia), including all subsidiaries, affiliates, facilities, and their personnel.

PURPOSE

To ensure all collection activities involving patients and third parties are completed timely, accurately, and properly documented.

POLICY

Acadia's Business Office Director (BOD) is responsible for the collection of patient accounts and identifying or resolving any obstacles in the collection process. The Business Office staff shall actively pursue payment from self-pay, private, and third-party payors on all outstanding account balances. Collection efforts should continue until an account balance is zero by means of payment or the appropriate adjustment. All collection activity pertaining to patients and third parties will be conducted timely as well as accurately documented in the patient accounting system.

Procedure

Accounts are assigned to the Business Office staff alphabetically by Financial Category (FC) or by formula. All billing and collection employees in the business office are cross trained as backup for all payors when needed. Each biller and/or collection employee maintains 35 to 45 accounts per day depending on the facility's payment sources and

levels of care. All collection activity for all accounts should be clearly documented on the patient's account within the patient accounting system. This documentation should include, at a minimum, the following:

- Collector's name;
- Date of Activity;
- Name and phone number of person contacted;
- Current status of the claim;
- Summary of actions, discussions, resolutions, due dates, etc. Any check numbers and check dates, if applicable.

Biller and collector employees should process all payments and correspondence received each day within 72 hours of receipt to ensure accounts are paid correctly. All contractual adjustments should be completed in accordance with the Contractual and Patient Account Adjustments Policy. All Administrative, Charity and Denial

Adjustments should be completed and processed by the BOD in accordance with the Administrative, Denial, and Charity Adjustments Policy.

All denials are to be accounted for by logging and tracking them in the patient accounting system and in the Sharepoint Denial Log. All denials should be handled in accordance with the Denial Review Policy. Accounts in an appeal status shall have follow up no later than every twenty-eight (28) days. Facilities may choose to use internal and/or external resources in appealing denials regardless of the level of appeal.

Patient complaints should be forwarded to the Business Office Director (BOD) for review. BOD will review complaints with the facility Chief Financial Officer or Chief Executive Officer (CFO/CEO) for the validity of any issue reported and work to resolve them immediately.

Returned refunds and mail items will be followed up on within 10 business days of receipt. When bankruptcy notifications are received, the biller/collector will follow the process for bankruptcy notifications to patients as disclosed in the Bankruptcy Notification Policy.

For all accounts due by third party- payors, the Business Office must confirm that the payor received the claim within 14 days of submission for paper claims and 7 to 10 days for electronic submissions.

- Collection efforts for these billed claims should take place every 14 days or more often as circumstances or payor practices may require.
- Subsequent follow-up will occur no later than every 14 days, on average, until the expected payment amount is received.

For all self-pay/private pay accounts, the Business Office will send monthly statements to and utilize an Early Out Vendor or Vendor, as defined below. Early Out Vendors

contract with the facility to assist in seeking collection of these payment accounts. Accounts are placed in and then returned through an automated process which must be reconciled by the BOD on a monthly basis. The placement process goes as follows:

- Self-Pay accounts are shared with Early Out Vendor 5 days post discharge.
- Self -Pay after Insurance/Medicare are shared with Vendor once the accounts have been placed in these financial Categories.
- Certain financial Categories are not a part of the automated process.
- Accounts are returned from the Early Out Vendor within 120 days.
- Certain accounts will need to be reviewed for collection agency placement. Once the Early Out Vendor's efforts are exhausted, the accounts will be placed with a collection agency in accordance with the Bad Debt Write Offs Policy.

AR/ MEETING REVIEW

The AR Review process is part of the standard Business Office practice. A Summary Aging report from the patient accounting system should be tracked monthly to identify unfavorable trends. System-generated, payor-specific account lists should be used to efficiently address multiple open accounts with payors. High-dollar accounts and accounts aged over 60 days should be prioritized and worked with greater urgency. In order to identify/resolve obstacles to the collections of patient accounts receivables (AR), it is recommended that the BOD/CFO have regularly scheduled AR meetings involving key departments such as Admissions and Utilization Management as well as the Biller/Collectors. The meeting frequency may be adjusted based on the facility's performance against key metrics, including cash collections, AR days, and bad debt expense.

Each weekly AR Meeting should focus on accounts/payor issues affecting cash collections and bad debt expense. The BOD should "Know the Bad Debt Roll" which is defined by each facility's individual bad debt policy. A schedule of working aging accounts each week in addition to working current accounts will assist the BOD in knowing what issues are occurring in the patient accounts well before they become bad debt expense.

A recommended schedule for working aging accounts is as follows:

- Week 1/Month End-Accounts over 181 days old and Credit Balances
- Week 2 - Accounts 151-180 days old
- Week 3 - Accounts 121-150 days old
- Week 4 - Accounts 91-120 days old
- Start over with Week 1. If there is a Week 5 then it can be used to redouble your efforts on the significant known payor issues.

Use of a Third-Party Debt Collector Agency

Upon the writing off of debt, the facility contracts with a third-party collection agency to again assist in pursuing the collection of patient debts on behalf of the facility. Patient debt will not be advanced for collection until the facility's Business Office has reviewed the account and approved the advancement of debt to collection. The facility holds patient debt in collection for up to four months before sending the bill to collections. If a patient is attempting to qualify for eligibility under the hospital's charity care policy and is attempting in good faith to settle an outstanding bill with the hospital, the hospital shall not send the unpaid bill to any collection agency, debt buyer, or other assignee unless that entity complies with the applicable provisions under California law.

Also, before sending a bill to collections, the facility provides notice to patients. The notice will include the following information: (a) the dates of service of the bill assigned

to collections; (2) instructions on how to obtain an itemized bill; (3) the name and plan type of the patient's health insurance on file; (4) an application to the facility's charity care and financial assistance policy and; (5) dates relating to when the patient was sent a notice about applying for financial assistance. The patient will also receive notice containing a summary of nonprofit credit counseling services and the patient's rights about fair treatment, including that patients cannot be contacted before 8:00 am or after 9:00 pm.

Once advanced for collections, the Business Office will be responsible for maintaining oversight of collections activity. If the facility elects to utilize a collection agency, it will enter into a written agreement with the collection agency to ensure that the collection agency will adhere to the facility's standards and scope of practices. This agreement shall require the affiliate, subsidiary, debt buyer, or external collection agency of the hospital that collects the debt to comply with the hospital's definition and application of

a reasonable payment plan, as defined per California code. The policy shall not conflict with other applicable laws and shall not be construed to create a joint venture between the hospital and the external entity, or otherwise to allow hospital governance of an external entity that collects hospital receivables. In determining the amount of a debt a hospital may seek to recover from patients who are eligible under the hospital's charity care policy or discount payment policy, the hospital may consider only income as limited by law.

The facility does not sell its debt to a debt buyer or collection agency, and at no point does the collection agency or Early Out Vendor take ownership of the patient's debt or account. The facility will not use information obtained from improper channels and shall not use monetary asset documentation collect purpose than for the purposes of determining discount or charity care eligibility for collection activities. A hospital, any assignee of the hospital, or other owner of the patient debt, including a collection

agency or debt buyer, shall not: (1) Report adverse information to a consumer credit reporting agency; or (2) Commence civil action against the patient for nonpayment before 180 days after initial billing.

A collection agency, debt buyer, or other assignee that is not a subsidiary or affiliate of the hospital shall not, in dealing with any patient under the hospital's charity care or discount payment policies, use as a means of collecting unpaid hospital bills, any of the following:

- A wage garnishment, except by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for which it believes that the patient has the ability to make payments on the judgment under the wage garnishment, which the court shall consider in light of the size of the judgment and additional information provided by the patient before or at the hearing concerning the patient's ability to pay, including information about

probable future medical expenses based on the current condition of the patient and other obligations of the patient.

- Notice or conduct a sale of any real property owned, in part or completely, by the patient.
- Liens on any real property.