Status **Active** PolicyStat ID **10590662**

Origination	11/2021
Last Approved	11/2021
Next Review	11/2022
Owner	Mohua Mukherjee: Assistant Vice President, Revenue Cycle Services
Area	Department - Patient Financial Services

PFS - Hospital Accounts Receivables Handling Process and Procedure

I. PURPOSE

A. The purpose of this policy is to establish a standardized process for handling accounts receivables for North Bay facilities. This policy will address the trajectory of accounts to various stages in the Revenue Cycle to include but not limited to cycle billing, bad debt, stop-loss, and government Medi-Cal copayments.

II. POLICY

A. To ensure hospital account receivables are handled consistently throughout the Revenue Cycle and balances are resolved to proper and logical conclusion for all account status including AR cliff aging.

III. DEFINITIONS

A. **Account Receivables Cliffing:** Accounts fully reserved by finance at 360 days regardless of payer or account status

B. **Bad Debt:** Revenue due to facilities but are not collected from self-pay, balances after insurance, third-party liability

C. **Contractual Allowances:** Amount of billed charges for covered services which the facility is not entitled under existing contractual terms and provision with payers.

D. **Billing Interim Cycle:** Insurance billing that occurs at monthly intervals where claims are prepared and sent to payers while the patient is still in-house

E. **Expected Reimbursement:** Full reimbursement NorthBay is expected to receive on claims that have been submitted to payer or patient based on contractual provision and terms.

F. **Stop-Loss Billing:** Additional Reimbursement expected from high-dollar claims based on payer terms and provision and is normally handled different than lower dollar claims process.

G. **Transaction Codes:** Codes used to append adjustment towards accounts such as contractual adjustments, bad debt, charity, denied charges. These codes reduce the gross AR when applied appropriately.

IV. PROCEDURE/GUIDANCE

A. **Patient Financial Services**

1. All patient hospital accounts with a net balance of $2,500 or *greater,* regardless of age and/or financial class are to remain in active AR inventory unless status has been determined as below:
    a. Account is considered to be uncollectible and all efforts have been exhausted by PFS staff (1st and 2nd appeal and net account down has occurred) and
    b. Account is adjusted to bad debt, charity, or denial
2. The Business office will note in the host system the reason the account is being adjusted as well as thorough documentation of reason efforts were exhausted.
3. Account balance *less* than $2,500 net may be routinely adjusted via automation process to bad debt status at the age of 360 days from discharge.
    a. Accounts should be moved to bad debt at net expected reimbursement balance.
    b. Contractual allowances should be posted to the account via contractual separate transaction code
    c. Subsequent payments on account balances that were previously written off will post as a bad debt recovery payment.

B. **Uncollectible Accounts:**

1. When accounts have been identified as uncollectible regardless of age, the following write off process will occur:
    a. Pure self-pay accounts will have an 85% discount applied to hospital account using the uninsured transaction code as appropriate.
    b. A 50% discount will be applied to Ambulatory accounts and Ambulatory Surgery Center accounts will be paid in full in advance prior to services provided.
    c. If patient qualifies for financial assistance, the appropriate charity transaction code will be applied once patient has been screened according to NorthBay's Financial Assistance policy.
    d. Remaining balances should be adjusted off and applied towards bad debt transaction code as last resort as appropriate.

e. For all other patients, including secondary balances due from another payer, remaining expected reimbursement amount should be written off to bad debt transaction code, only after applicable contractual allowances have been applied.

C. **Denials**

1. PFS staff billing gross charges and receives partially denied claims should adjust to the net expected reimbursement when a first level appeal has been initiated. Fully denied claims should be adjusted to net expected reimbursement when the first level is denied, and a second appeal has been submitted by the business office. All denial write-offs should follow the requisite approval process of leadership.

Patient Account Activity	**PFS process**
Copayment or deductible has been collected	Account remains at gross
Full claim denial, PFS will file a first level appeal.	Account remains at gross
Full claim denial, when first level appeal has been submitted, a second level appeal will be filed by PFS.	Net Down Required as account is continually be pursed
Partially denial and/or underpayment, where the primary payer has partially paid and partially denied the claim, the business office will decide to appeal. **Example**, primary payer pays per diem on a large acct that is subject to a stop-loss provision.	Net Down Required as account is continually be pursed

D. **Medicaid Cycle Billing:**

1. North Bay will not send cycle or interim bills to state Medicaid programs that pay under the APR DRG methodology. Interim bills are designed to get paid per-diem rates during the patient stay, while a final bill is sent from admission to discharge to capture the entire APR DRG payment. The combination of the per diem payments and the APR DRG payment causes overpayments and credit balances that create more administrative work than necessary.

    A. **EXCEPTION**: Accounts with a long length of stay would be expected to bill a cycle claim every 60 days to allow for cash flow on accounts.

2. **MEDI-CAL COPAYS**

    a. State of California facilities will not be required or is expected to collect outpatient copayments from Medi-Cal recipients.

3. Medi-Cal Provider Regulations manual says, "The amounts are in addition to the usual provider reimbursement and no deduction will be made from the amounts otherwise approved by the DHCS Fiscal Intermediary (FI) for payment to the provider. The collection of the copayment by the provider is optional." (Source)

4. Because no deduction will be made from normal Medi-Cal reimbursement, and copayment responsibility is not reflected on the Medi-Cal explanation of benefits (EOB), the collection of copayments creates nominal credit balances that create more administrative work than necessary.

E. **Stop-loss Billing**

1. Claims that exceed stop-loss limitations will ONLY be billed to the payer's stop-loss unit. No claims should be sent to the normal billing address to receive per-diem payments. These stop-loss units are equipped to pay the claim appropriately and should be expected to do so.
2. **EXCEPTION**: Accounts with a long length of stay would be expected to bill a cycle claim to the per-diem unit every 60 days to allow for cash flow on those accounts.

F. **OTHER**

1. Pure self-pay or balance after insurance accounts in current payment plans shall remain in active AR and shall not be moved into bad debt unless the patient falls out of compliance with the terms in the payment plan and it is determined to be uncollectible. (i) If pure self-pay or balance after insurance account enters a payment arrangement after moving to bad debt, it should remain in bad debt and the payments posted as bad debt recovery.

V. APPROVAL REQUIREMENTS

A. Policy Owner/Content Expert: Assistant Vice President, Revenue Cycle Services

B. Vice President, Chief Financial Officer

Printed version is for reference only, refer to online policy in PolicyStat for accurate version.

Approval Signatures

Step Description	Approver	Date
CFO	Michele Bouit: Vice President & CFO	11/2021
Policy Owner	Mohua Mukherjee: Assistant Vice President, Revenue Cycle Services	11/2021