AHMC Healthcare Inc.	CBO POLICY & PROCEDURE MANUAL	Page
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Title:	BAD DEBT POLICY AND PROCEDURE		
DEPART:	CENTRAL BUSINESS OFFICE	Originating Department: Responsible Persons:	Central Business Office Central Business Office
		Approved by:	

PURPOSE:

To establish and promulgate the policies and procedures related to the administration of Bad Debt by AHMC.

POLICY:

1. Timely Follow-up- All hospital patient accounts (Medicare, Non-Medicare) will be billed in a timely manner and followed-up on for collection using all reasonable means as approved by the hospital in accordance with the Federal Fair Debt Collection Practices Act.

2. Collection Period- All hospital patient accounts (Medicare, Non-Medicare) will be followed-up on for collections for a period not to exceed one hundred twenty (120) days. This process includes in-house, pre-collect, and bad debt collections services. If at the end of the collection period no response and/or payment have been received, the hospital will write off these accounts to bad debts. Specifically, for Medicare bad debts (Deductible and Coinsurance), the provider will request from outside collection agencies a listing of all Medicare claims that are considered uncollectible and where all collection efforts have ceased. These can include all dates of services prior to and including the FYE where these uncollectible deductible and coinsurance amounts will be recorded on the filed cost report.

PROCEDURES: (Applies to Non-Medicare and Medicare with comparable amounts)

1. In-House Collections - All accounts are worked by the designated employee clerk for a period not to exceed ninety (90) days. If no response or payment is received during this period, the account information is outsourced to an outside collection agency.

2. Pre-Collect Process – Issue initial billing on or shortly after discharge or death to the party responsible for the patient's personal financial obligations. Four statements are sent at thirty (30) day intervals including Goodbye letter. If still no response or payment, the account is submitted for bad debts collection processing.

NOTE: When a collection agency is used, the provider will refer all uncollected patient charges of like amount to the agency without regard to class of patient. Therefore, if uncollected non-Medicare patient charges with amounts comparable to the individual Medicare deductible and coinsurance amounts, refer those Medicare deductible and coinsurance amounts.

3. Statement Billing Cycles - Balance due statements are generated every 30 days after the date of the initial statement.
After 120 days a final statement, Goodbye letter, is generated, the account will be written off to bad debt and referred to a collection agency, predetermined by the service rendering hospital.

The third statement includes the FAA, Financial Assistance Application.
No account will be assign to collections prior to 120 days from the first patient billing, or while a financial assistance, application is being process.
Patients on a formal payment plan will receive a monthly statement of the current amount due until the payment plan is satisfied.

Before assigning a debt to collections AHMC Healthcare must send notice containing: (1) Date of Service; (2) name of Entity to whom debt is being assigned; (3) instructions for how to get an itemized bill; (4) the name and type of health coverage plan for the patient on record with the hospital at the time of services or a statement that the hospital does not have this information; (5) application for Financial Assistance; (6) the dates patient was originally sent notice about applying for FAA.

4. Payment Arrangements - All patients may contact the hospital for payment arrangements. All arrangements will be made with the following process:

- Nine (9) month payment plans are offer via patient portal (AHMCHealth.PatientSimple.com).
- Payment plans beyond 9 months will require approval from the Director of Patient Services.
- Any previously agreed payment not received with the specified period will be consider in default and may be refer to our collections agency.
- When a monthly payment plan is arrange, the Patient Account Rep will document and code the account under the Patient Terms.

1. Patients set up on an agreed monthly payment plan and making monthly scheduled payments will not be assign to collections unless the payment plan is defaulted.

5. Bad Debt Collections- Accounts submitted for bad debt collections are outsource to a minimum of two (2) competing collection agencies for collections follow-up. This bad debt collection process includes continued efforts to collect hospital balances through telephone calls, certified letters, and all other reasonable means as deemed appropriate by the hospital.

6. Recoveries- All recoveries of previously written off bad debts will be recorded with segregation of Medicare bad debt recoveries. Any prior bad debts recoveries will be offset against any claimed Medicare bad debts.

DEFINITIONS:

1. "Bad Debt" is defined as expenses resulting from treatment for services provided to a patient/or guarantor who, having the requisite financial resources to pay for health care services, has demonstrated by his/her actions an unwillingness to comply with the contractual arrangements to resolve a bill or satisfy their outstanding obligations.

2. "Contractual Allowance" is defined as the difference between the levels of payment established under a contractual agreement and the patient's billable charges.

3. "Charity Care" means inpatient and outpatient medical treatment and diagnostic services for uninsured or underinsured patients who cannot afford to pay for the care according to established hospital guidelines. Charity Care does not include bad debt or contractual allowances from government programs and insurances, but may include insurance co-payments or deductibles, or both.

4. "Financial Assistance Application" (FAA) is financial aid to a patient or responsible party for the billing amounts the patient is responsible for, regardless if the patient has insurance or otherwise. Financial assistance is provided to patients with medically necessary healthcare needs with low-income, uninsured or underinsured, ineligible for a government program, and is otherwise unable to pay for medically necessary care based on their individual family financial situation. To determine if a patient/guarantor qualifies for financial assistance, we need to obtain certain financial information.

Below are the adjustment codes for Non-Medicare & Medicare Bad Debt for all eight facilities:

NON-MEDICARE BAD DEBT

ADJ CODE	DESCRIPTION
99001	BAD DEBT WRITE-OFF
99012	BAD DEBT RECALL
99004	BAD DEBT RECOVERY

MEDICARE BAD DEBT

ADJ CODE	DESCRIPTION
99015	MEDICARE SELF-PAY BAD DEBT WRITE-OFF
99025	MEDICARE SELF-PAY BAD DEBT RECALL
99004	BAD DEBT RECOVERY

SAN GABRIEL VALLEY MEDICAL CENTER

NON-MEDICARE BAD DEBT

ADJ CODE	DESCRIPTION
99001	BAD DEBT WRITE-OFF
99013	RECALL BAD DEBT
99004	BAD DEBT RECOVERY

SAN GABRIEL VALLEY MEDICAL CENTER

MEDICARE BAD DEBT

ADJ CODE	DESCRIPTION
99015	MEDICARE SELF-PAY BAD DEBT WRITE-OFF
99025	MEDICARE SELF-PAY BAD DEBT RECALL
99004	BAD DEBT RECOVERY