Policy Title: Bad Debt Allowance and Adjustment		Department / Function: Business Office
Effective Date: 7/1/2014	Policy Number: REV001	Approval: Eudora Cannon
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I. PURPOSE:

The purpose of this policy is to establish procedures for Ernest Health and its affiliated hospitals ("Ernest") to follow in order to handle bad debt in a timely and accurate manner.

II. POLICY:

It is the policy of Ernest Health and its affiliated hospitals to monitor patient account balances to ensure proper valuation and timely collection through reasonable collection efforts.

DEFINITIONS:

Bad Debts: Amounts considered uncollectable from accounts and notes receivable that were created or acquired in providing services.

Charity Allowances: Reductions in charges made by a provider of services because of the patient's indigent or medical indigent status.

Courtesy Allowances: Reduction in charges by the provider in the form of an allowance to physicians, clergy, members of religious orders and others as approved by the provider's governing body, for services received from the provider.

III. PROCEDURE:

A. **Reasonable Collection Efforts**
   1. Collection efforts will be reasonable and the same as collection efforts for Medicare and non-Medicare patients.
   2. A bill notifying the patient or responsible party of their financial obligations must be issued on or before 120 days after the latter of one of the following:
      a. The date of the payer's remittance advice that results from processing the claim for services furnished to the patient and generates the patient's cost sharing amounts.
      b. The date of the remittance advice from the patient's secondary payer, if any.
      c. The date of the notification that the patient's secondary payer does not cover the service furnished to the patient.
   3. Collection efforts will include other actions such as subsequent billings, collection letters, and telephone calls, emails, text messages, or personal contacts with the patient or responsible party.
   4. Collection efforts must last at least 120 days after C.2.a.-C.2.c. above before being written off as uncollectible.

        a. A new 120-day collection period starts each time a payment is received within a 120-day collection period.
    5. **Collection agencies** may be used to perform collection efforts provided that:
        a. The gross amount collected is reduced from the beneficiary's account receivable
        b. Fees charged by the collection agency are included as administrative costs
        c. All collection efforts are ceased and collection accounts returned to Ernest before claiming any unpaid amounts as Bad Debt.

B. **Medicare Bad Debt**
    1. In order to qualify as Medicare bad debt, the following criteria must be met:
        a. The debt must be related to covered services ans derived from deductible and coinsurance amounts.
        b. Ernest must be able to establish that reasonable collection efforts were made.
        c. The debt was actually uncollectable and claimed as worthless.
        d. Sound business judgment established that there was no likelihood of recovery at any time in the future.
    2. **Non-Allowable Medicare Bad Debts**
        a. The following are NOT ALLOWABLE Medicare bad debts and will not be included on the cost report:
            i. Medicare Part B coinsurance/deductible resulting from charges paid under a Fee Schedule
            ii. Medicare Advantage coinsurance/deductibles
            iii. Any Medicare coinsurance/deductibles written off as small balance write offs where collection efforts were not made
            iv. Medicare non-covered charges
            v. Charity, courtesy and third-party payer allowances
    3. **Medicare Part B Coinsurance**
        a. Revenue codes paid by fee screens will be written off as traditional (Non-Medicare allowable) bad debt.
        b. Cost based revenue codes will be written off to the applicable Medicare Part B bad debt transaction code.
    4. **Dual Eligible/Medicaid Crossovers**
        a. For Medicare beneficiaries eligible for Medicaid coverage, Medicare will be treated as the primary payer with any related deductible and coinsurance amounts being the responsibility of Medicaid.
        b. Medicaid must be billed for its portion of any deductible and coinsurance amount.
        c. Any portion of the deductible or coinsurance not paid by Medicaid is deemed a Medicare bad debt and claimed on the Medicare cost report for the year in which the bad debt arises.
        d. The approved write-off amount will be posted as Medicare bad debt after receipt of the Medicaid remittance advice.
        e. Documentation of the bad debt arising from the Medicare/Medicaid crossover will inlcude a copy of the Medicaid remittance advice showing the crossover claim resulting in Medicaid payment or non-payment.
    5. **Collection Process**
        a. The collection process will include, and be made available to Medicare contractors upon request:
            i. This Bad Debt policy

ii. Patient account history documents showing the dates of various collection actions such as the issuance of bills to the beneficiary, follow-up collection letters, reports of telephone calls and personal contact, etc.

iii. The beneficiary's file with copies of the bill(s) and follow-up notices

6. **Medicare Bad Debt Documentation**
   a. Each Medicare bad debt write-off will be supported by a "Medicare Bad Debt Write-off Form" with attached supporting documentation.
      i. The Billing Office designee will review and approve the Medicare Bad Debt Write-off Form.
   b. Supporting attachments will vary depending if the patient is Medicaid eligible or non-eligible.
      i. Medicaid Eligible Patients
         - Medicare Bad Debt Write-off Form approved by the CBO designee
         - Proof of Medicaid eligibility corresponding to the dates of service
         - Medicare remittance advice identifying the deductible and/or coinsurance amount that agrees to the service date and supports the amount of the deductible and/or coinsurance claimed.
         - A copy of the Medicaid remittance advice showing a Medicaid payment or non-payment may be used as evidence of the Medicare bad debt, or if not billed, a calculation of the non-payment if the crossover claim had actually been filed with Medicaid.
         - Patient Account Detail/Payment History showing all charges and payments applied to the account and dates billed
         - Copy of the claim form.
      ii. Non-Medicaid Eligible Patients without Use of a Collection Agency
         - Medicare Bad Debt Write-off Form approved by the CBO designee
         - Medicare remittance advice identifying the deductible and/or coinsurance amount that agrees to the service date and supports the amount of the deductible and/or coinsurance claimed.
         - Copy of all collection effort notes on the patient account (e.g. collection contact notes, subsequent billings, follow-up letters, reports of telephone and personal contact)
         - Supporting documentation to confirm that the write-off date is greater than 120 days from the date the first statement was mailed to the patient/guarantor or the date of the last payment (whichever is later)
         - All charges and payments applied to the account
         - Copy of the claim form
      iii. Non-Medicaid Eligible Patients with a Collection Agency Used
         - Medicare Bad Debt Write-off Form approved by the CBO designee
         - Medicare remittance advice identifying the deductible and/or coinsurance amount that agrees to the service date and supports the amount of the deductible and/or coinsurance claimed.
         - Copy of all collection effort notes on the patient account (e.g. collection contact notes, subsequent, follow-up letters, reports of telephone and personal contact)
         - Copy of the report received or screenshot from the collection agency showing the patient's name, date account placed with the agency,

amount placed with the agency, account balance and the date the account was deemed worthless

- Supporting documentation to confirm that the write-off date is greater than 120 days from the date the first statement was mailed to the patient/guarantor or the date of the last payment (whichever is later)
- All charges and payments applied to the account
- Copy of the claim form

7. **Medicare Bad Debt Log**
    a. All hospitals will maintain a Medicare Bad Debt Log for Medicare cost report purposes.
    b. The Corporate Reimbursement Department is responsible for auditing the logs monthly for interim review purposes.
        i. An average of three accounts per hospital will be selected for review
        ii. The reviews are intended to verify that allowable Medicare bad debts are included in the calculation of reimbursable bad debt reported on the Medicare cost report, that adequate documentation exists to support each Medicare bad debt write-off, that non-Medicaid claims are not written off prior to 120 days from the date the first bill was mailed to the patient and to ensure the Medicare bad debt write-offs have been processed in a timely manner
        iii. Reviews must occur prior to the official filing of the cost report
        iv. If any major discrepancies or lack of documentation are noted during the review, the associated bad debt will be removed from the log and any income previously booked will be reversed.
    c. At the end of the Medicare cost report year, the hospital CFO/Controller will coordinate with the Corporate Reimbursement Department to review the bad debt log.
    d. The log will be certified by the CFO/Controller and will then serve as the Medicare Bad Debt Log used for filing the annual Medicare cost report.
8. **Reporting Bad Debt & Recoveries Reimbursed in Prior Periods**
    a. Uncollected deductibles and coinsurance are written off and reported as allowable bad debts in the cost reporting period in which the accounts are deemed to be worthless.
    b. Any payment on the account made by the patient or a responsible party, after the write-off day, but before the end of the cost reporting period, must be used to reduce the final bad debt for the account claimed in that cost report.
    c. If an amount written off as a bad debt and reimbursed by the program in a prior cost reporting period is recovered in a subsequent reporting period, the recovered amount must be used to reduce the reimbursable costs in the period in which the amount is recovered.
        i. The amount of the reduction must not exceed the actual amount reimbursed for the related bad debt in the applicable prior cost reporting period.

C. **Indigent Patients**

1. A patient may be deemed indigent or medically indigent if:
    a. The individual has been determined to be eligible for the state Medicaid program; or
    b. Ernest determines the patient is indigent based on customary methods.
        i. The indigence is determined by Ernest/the hospital and not by the patient
        ii. Ernest will take into account a patient's total resources, which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses.
        iii. Any extenuating circumstances that would affect the determination of the patient's indigence will also be considered

iv. Ernest will determine that there is no source other than the patient that would be legally responsible for the patient's medical bill; e.g. title XIX, local welfare agency and guardian
v. The patient's file will include documentation of the method by which indigence is determined in addition to all backup information to substantiate the determination.

c. Once indigence is determined and Ernest concludes there has been no improvement in the individual's financial condition, the debt may be deemed uncollectable without applying the procedures under Section C.

D. **Deceased Patients**

1. If a patient is deceased then collection attempts still must be pursued (if Medicaid is not a secondary payer).
2. If possible, Ernest will obtain proof of death such as:
   a. Copy of the death certificate
   b. Obituary
   c. On-line passport sheet showing date of death
3. Letters may be sent to "The Estate of John Doe" and at least one must be sent after determining the patient is deceased.
4. Ernest will determine if there is another responsible party such as a spouse or guardian.
   a. If there is no responsible party, then Ernest will contact the patient's county probate office to determine whether there is an estate
   b. If there is no estate, obtain verbal or written verifcation and place the documentation in the patient's file prior to writing off as bad debt.