



Saint Agnes Medical Center

EFFECTIVE DATE: July 1, 2016
Revised 12/24

PROCEDURE TITLE:

Bad Debt Policy

PURPOSE

The purpose of this policy is to define how patient bad debt accounts are identified and handled for Saint Agnes Medical Center.

PROCEDURE

Guarantor accounts with unpaid balances (a) where a patient has been determined to be ineligible for financial assistance or (b) that are greater than 180 days from the first patient post-discharge billing statement; and offer of financial assistance (“Billing Statement”) without response, are considered bad debt; under the authority of the local Chief Financial officer may be transferred to an external collection agency; and after all aspects of this procedure are applied and reasonable collection efforts made, the outstanding debt reported to Credit Bureaus and/or legal action taken.

I. Qualifications for Bad Debt Review:

- A. If the account has an unpaid balance, is greater than 180 days from the first patient post- discharge Billing Statement, and is < \$10,000,
 - 1. If the patient is uninsured, the account will be scored using a predictive tool (PARO) to determine eligibility for presumptive support (i.e., financial assistance).
 - a. If qualified for 100% presumptive support, the account balance is reduced to zero and a letter is sent to the patient.
 - b. If qualified for partial presumptive support, the account balance is reduced by the appropriate discount; a letter with the new adjusted balance is sent to the patient along with instructions on how to be considered for more generous support; and the account is then transferred to an external collection agency.
 - c. If patient does not qualify for presumptive support, it will be transferred to an external collection agency.
 - 2. All other insured patients are automatically transferred to an external collection agency.
 - 3. Physician services accounts <\$1,000 are reviewed for bad debt criteria and manually sent to an external collection agency without presumptive support review.
- B. If the account has an unpaid balance, is greater than 180 days from the first patient post- discharge Billing Statement, and is \$10,000 or greater,
 - 1. The account will appear on a report that is worked by a Financial

Assistance Representative.

- a. The Representative will verify that services are medically necessary.
- b. If services are medically necessary, the Representative will then verify that all payer resources (e.g., Medicaid, county indigent programs, commercial insurance, liability insurance, Crime Victim funds, worker's compensation, etc.) have been exhausted.
 - i. If payer resources have not been exhausted, the Representative will determine whether a claim needs to be sent.
 - ii. If the payer resources have been billed and the claim processed as in-network, leaving the balance as patient responsibility, the account will be reviewed for presumptive support.
 - iii. If the payer resources have been denied due to non-cooperation from the patient or the services are out-of-network, the account will be transferred to a collection agency.
- c. If the account qualifies for presumptive review, the Representative will review for presumptive support qualifiers (e.g., homeless, food stamp recipient, deceased with no spouse and/or estate, member of religious organization with vows of poverty). If no qualifier is found, the Representative will use a predictive tool (PARO) to determine eligibility for presumptive support.
 - i. If qualified for 100% presumptive support, the Representative will complete a Presumptive financial assistance request and obtain the appropriate approvals (see Approval Levels below). When approved, the balance is reduced to zero and a letter is sent to the patient.
 - ii. If qualified for partial presumptive support, the Representative will complete a Presumptive financial assistance request and obtain the appropriate approvals (see Approval Levels below). When approved, the account balance is reduced by the appropriate discount; a letter with the new adjusted balance is sent to the patient along with instructions on how to be considered for more generous support; and, the account is then transferred to a collection agency.
- d. If the account does not qualify for presumptive review, the Representative will complete a Bad Debt request and obtain the appropriate approvals (see Approval Levels below). When approved, the account is then transferred to a collection agency.

- C. Information obtained from income tax returns, paystubs or monetary asset documentation collected for discount payment or charity care determinations will not be used for collection activities.

II. Accounts in Collections

- A. An account that gets transferred to a collection agency will receive their first statement showing the referring hospital; balance owing; information regarding the hospital's financial assistance program; and notice that the outstanding debt will be reported to Credit Bureaus if not paid within 30 days (i.e., an Extraordinary Collection Action or ECA).
 1. If the age of the account is <240 days from the first patient post-discharge billing statement, it may be eligible for financial assistance. If financial assistance is granted, all reasonably available measures to reverse any ECAs related to amounts no longer owed by the patient.

2. Accounts with balances not paid within 180 days can be transferred to a secondary collection agency. In those instances, the primary collection agency will stop reporting to the Credit Bureau and the secondary agency will initiate credit reporting.
3. Legal action may be pursued for individuals who have the means to pay, but do not pay, or who are unwilling to pay. Appropriate approval must be obtained by the functional leader for Patient Financial Services prior to commencing a legal proceeding or proceeding with a legal action to collect a judgment (i.e., garnishment of wages, debtor's exam).
4. Liens may be pursued on property of individuals who have the means to pay, but do not pay, or who are unwilling to pay. Liens may be placed for the portion of the unpaid amount. Placement of a lien requires approval by the Trinity Health or Regional Health Ministry's (RHM) CEO/CFO, or the functional leader for Patient Financial Services. Liens on primary residence can only be exercised upon the sale of property and will protect 50% of the equity up to \$50,000 in the property.
5. Actions against the debtor's person, such as arrest warrants or "body attachments" will not be pursued.
6. The RHM reserves the right to discontinue collection actions at any time with respect to any specific account.

**Trinity Health
West Region Shared Service Center
Approval Levels for Financial Assistance and Bad Debt**

<u>Level of Adjustment</u>	<u>Position</u>
Up to \$4,999	Staff
\$5,000- \$9,999	Team Lead
\$10,000-\$14,999	SSC Manager
\$15,000-\$24,999	Regional Manager, Patient Accounting
\$25,000-\$49,999	Regional Director, PFS
\$50,000-\$74,999	VP, Finance
\$75,000 & over	CFO

* Presumptive Support adjustments, as determined via the automated predictive model will be processed via an automated process. Amounts up to \$9,999.99 will not require signed approval to further support the automated process.