



DEPARTMENT: Revenue Cycle	POLICY DESCRIPTION: Billing & Collection Policy
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SCOPE:

This policy applies to all Carroll County Memorial Hospital (CCMH) and Jefferson Medical Group (JMG) patient accounts. It establishes uniform standards for: (a) billing and payment terms; (b) payment plans and third-party financing; (c) integration with the Financial Assistance Policy (FAP); (d) small-balance and administrative write-offs; (e) bad-debt/uncollectible designation and referral to external collections; and (f) documentation, controls, reporting, and compliance. The objective is to ensure consistent, fair, and compliant account resolution practices while maintaining strong internal controls and positive patient experience.

DEFINITIONS:

- **Administrative Write-Off:** Removal of a balance due to operational/administrative reasons unrelated to patient financial hardship (e.g., clerical or system errors, de minimis amounts, grievance outcomes, or timely-statement issues).
- **Small Balance Write-Off (SBWO):** Automatic write-off of residual debit/credit balances at or below policy thresholds for accounts in self-pay status.
- **Financial Assistance Policy (FAP):** Separate policy describing eligibility, application, and processing for financial assistance; patients must be offered the opportunity to apply for FAP prior to any Extraordinary Collection Actions (ECA).
- **Bad Debt:** Patient-responsible amounts deemed uncollectible after reasonable billing efforts, payment plan opportunities, and FAP opportunities have been provided and documented.
- **Extraordinary Collection Actions (ECA):** Actions that may negatively affect a patient’s credit standing (e.g., referral to a collection agency); permitted only after required notices and waiting periods.
- **Credit Balance:** A negative patient balance resulting from overpayment, payer adjustments, or reversals; subject to due-diligence, refund, or unclaimed-property processing.
- **Uncollectible / Indigent:** Status applied when minimum criteria are met showing an account cannot be collected through reasonable internal/external efforts, including agency return as uncollectible or deceased/no estate cases.

POLICY:

1. Payment Terms & Statements

- a. **Standard Due Date.** Patient balances are due 30 days from the date of the statement unless a payment plan or approved financing is arranged.
- b. **Payment Methods & Self-Pay Discount.**
 - i. Accepted methods: cash, check, credit/debit card, online portal, or approved third-party financing.
 - ii. A self-pay contractual discount is applied to eligible self-pay accounts prior to financial assistance consideration.
- c. **Statement Schedule (minimum).** Initial statement (Day 0); second statement (≈ Day 30); third statement (≈ Day 60). Courtesy call/text/email/mail outreach may occur between statements. A pre-referral notice is sent at least 30 days before any ECA/referral. Earliest referral generally occurs no sooner than ≈ Day 120, provided all reasonable efforts and notices are completed.
- d. **Returned Mail & Address Updates.** Returned statements trigger address verification (e.g., skip trace/EMPI update). Document all attempts and reroute statements; do not proceed to ECA

without reasonable efforts to re-deliver notices.

2. Payment Plans & Third-Party Financing

- a. **Eligibility:** Available to any patient unable to pay the full balance. Standard hospital-based plans are 12 months unless otherwise approved.
- b. **Interaction with FAP:** Patients may apply for FAP while on a plan/financing; if approved, balances are reduced accordingly.
- c. **Extended/Adjusted Plans:** If the patient cannot meet a standard plan, extended or modified plans may be approved based on ability to pay with CFO or designated authorized official approval.
- d. **Default/Delinquency:** Two consecutive missed payments or three missed within six months constitute default.
- e. **Re-instatement:** Patients may request plan re-instatement after default; require a catch-up payment or revised terms with CFO or designated authorized official approval.

3. Financial Assistance

- a. Offer FAP information prior to any ECA; include plain-language instructions in statements and pre-referral notices.
- b. Assist patients with applications and required documents; consider presumptive/attestation paths if allowed by policy.
- c. Document all FAP communications (offers, applications, decisions) in the patient record; update balances accordingly when approved.
- d. Refer to the separate Financial Assistance Policy for eligibility criteria, verification standards, and timelines.

4. Collections & Extraordinary Collection Actions (ECA)

- a. **Pre-Referral Written Notice:** At least 30 days before any referral to an external collection agency, send a written notice that: (a) describes payment options, including payment plans and financing; (b) clearly explains FAP availability and how to apply; and (c) states that the account may be referred to collections if unresolved.
- b. **Reasonable Efforts & Channels:** Prior to any ECA, make reasonable efforts to reach the patient via mail, phone, text, email (as available/consented) to discuss resolution and FAP. Document all attempts and responses in the patient record.
- c. **Timing:** No ECA may occur until the 30-day pre-referral window has elapsed and all required FAP opportunities have been provided and documented.

5. Bad Debt Designation & Approval

- a. An account may be designated as bad debt only after all of the following are true:
 - i. All known third-party payers have adjudicated the claim, and the remaining balance is patient-responsible.
 - ii. The self-pay contractual discount has been applied (if applicable).
 - iii. The patient was offered a reasonable payment plan and subsequently defaulted, as defined by missed payments (two consecutive or three within six months), paying less than 75% of the required amount for over three months without approval, or defaulting on third-party financing.
 - iv. The patient was offered the opportunity to apply for FAP prior to any ECA.

Approval thresholds before classifying an account as Bad Debt:

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Account Amount	Approval Required
< \$5,000	None
> \$5,000	CFO or designated authorized official

6. Administrative Write-Offs

- a. Examples: clerical/billing errors (duplicate charges, miscoding, overpayments); system adjustments (misapplied/unapplied payments, rounding errors); insurance posting corrections; grievance-related adjustments; timely-statement issues.
- b. Timely-Statement Write-Off: Balance may be eligible when the first billing statement was not received within one (1) years post-discharge; document cause and supporting evidence.
- c. Documentation: Each request must include account number, reason, supporting documentation/screenshots, and the approver's signature.
- d. Processing & Controls: Update account with adjustment code; maintain audit trail; include in reporting to the CFO at their discretion.
- e. Approval thresholds for Administrative Write-Offs

Write-Off Amount	Approval Required
< \$500	Department Head / Patient Finance Supervisor
>\$500	CFO or designated authorized official

7. Small Balance Write-Offs (SBWO) – Self-Pay Status

- a. The following criteria will be used to determine write-off for small balances:
 - i. Debits: CCMH and Jefferson Medical Group – balances \leq \$9.99 are eligible for automatic write-off.
 - ii. Credits: CCMH and Jefferson Medical Group – balances \leq \$5.00 are eligible for automatic write-off.
- b. Balances outside SBWO parameters: Patient Accounting determines whether to bill, credit, and/or write off based on payer, dollar amount, and services rendered (see Late Charge Policy).
 - i. Debits:
 1. Carroll County Memorial Hospital: Patient Accounting will determine whether charges should be billed, credited, and/or written off based on payer, dollar amount, and services rendered. Refer to the Late Charge Policy for additional information.
 2. Jefferson Medical Group: Patient Accounting will determine whether charges should be billed, credited, and/or written off based on payer, dollar amount, and services rendered. Refer to the Late Charge Policy for additional information.
 - ii. Credits:
 1. All credit balances must be addressed within 12 months from the date the balance becomes a credit. If checks or funds are not accepted, returned, or resolved, the information will be recorded and sent to Unclaimed Property on or

around November 1st each year.

8. Uncollectable/Indigent Criteria & Process

- a. The following criteria must be met prior to writing an account off to uncollectible.
 - i. Patients have received three (3) statements and has been at the third-party collection agency for at least one year with no collection activity.
 - ii. The collection agency sends information to CCMH stating the account is uncollectible.
 - iii. Financial Counselor writes off account to uncollectible.
 - 1. If primary insurance is Medicare, account is to be written off to Medicare Uncollectible Write Off.
 - 2. If primary insurance is anything other than Medicare, account is to be written off to Uncollectible Write Off.
- b. Patient is deceased and has a balance remaining after insurance.
 - i. Balances less than \$1,000: Accounts with a remaining balance of less than \$1,000 shall be considered uncollectable and written off as follows:
 - 1. If primary insurance is Medicare, account is to be written off to Medicare Uncollectible Write Off.
 - 2. If primary insurance is anything other than Medicare, account is to be written off to Uncollectible Write Off.
 - ii. Balance is greater than \$1,000 with no estate identified: For accounts with a remaining balance greater than \$1,000, if no estate is identified within 12 months from the documented date of death, the balance shall be deemed uncollectable and written off as follows:
 - 1. If primary insurance is Medicare, account is to be written off to Medicare Uncollectible Write Off.
 - 2. If primary insurance is anything other than Medicare, account is to be written off to Uncollectible Write Off.
- c. Procedure:
 - i. Patient Accounting will review each account to determine if the established criteria has been met.
 - ii. Once this determination has been completed and the collection agency has sent documentation that the account is uncollectible, Patient Accounting will write off the account to Uncollectible Write Off or Medicare Uncollectible Write Off.
 - iii. Appropriate action will be completed in the account to indicate that it has been written off to uncollectible.

9. Documentation, Controls, & Auditing

- a. Document in the patient record: statements and reminders; payment plan offers/terms; missed payments/defaults; third-party financing communications; FAP notices/applications/decisions; and pre-collection letters.
- b. Maintain written approvals for all write-offs per threshold tables; ensure adjustment codes and notes support the transaction.
- c. Internal Audits: Periodically verify that FAP opportunities were offered prior to ECA; confirm adherence to criteria, timing, and documentation standards.
- d. Record Retention: Retain records and approvals in accordance with hospital record-retention



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policy and applicable regulations.

10. Reporting & Ongoing Review

- a. Periodic reporting of administrative write-offs and bad-debt classifications to the CFO; escalate high-value items or variances to the CEO.
- b. Periodic trend review of denials, defaults, and write-off drivers with Revenue Cycle and Finance leadership; implement corrective actions as needed.
- c. Annual policy review by Revenue Cycle leadership and Finance (or sooner if regulations or organizational practices change).

REFERENCES:

IRS §501(r) – Reasonable efforts prior to ECA (refer to hospital FAP for details).
Missouri Unclaimed Property law regarding credit balances