Collecting From Guarantors – NMOSC Facility only

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Section A: Purpose

Successful collection efforts with guarantors reduce the amount of money written off to bad debt.

Section B: Policy

NMOSC will use reasonable and consistent methods to collect patient balances. Contracted collection agencies will also follow the requirements of this policy. NMOSC and its contracted collection agencies will not discriminate between Medicare and non-Medicare accounts, either in their collection efforts or in their determination of collectability.

It is the policy of New Mexico Orthopaedic Surgery Center (NMOSC) to ensure that:

1. Patient statements are generated and mailed a minimum of once a month.

2. Collection efforts are evaluated after three months of no response from the guarantor.

3. Federal and state collection laws are followed.

4. If the third party payor chooses to reduce the amount paid to the facility in response to the discount the facility provided the patient when honoring the member's in-network benefit, the facility takes no further collection action towards the patient.

5. All Medicare patient balances written off due to complaints of patient care are to be reported immediately to the center Administrator and Western Litigation, Inc. who has been hired by USPI to report to CMS.

6. NMOSC will not engage in any extraordinary collection actions (as defined herein) against an individual to obtain payment for care before reasonable efforts have been made to determine whether the individual is eligible for assistance for the care under our Professional, Employee, Self-Pay, and Charity Discounts policy.

Section C: Persons Affected

Anyone involved in obtaining accurate payments from guarantors following day of surgery.

Section D: Responsibilities

1. The administrator is responsible for approving accounts written off to bad debt and deciding to accept a case scheduled for a patient who has not paid for a prior date of service.

2. The business office manager (BOM) is responsible creating a facility write-off approval form and obtaining approval from the administrator before writing off a guarantor's balance to bad debt in the PAS. The BOM is responsible for identifying accounts each month for bad debt write-off including any account submitted by collector.

3. The collector is responsible for sending patient statements, responding to all patient account inquiries, submitting a list of accounts for bad-debt write-off to the BOM and making collection calls.

4. The receptionist is responsible for changing addresses in the PAS when a change of address card arrives.

5. The business office manager is responsible for creating write off code WO390 in Advantx and transaction D code for SIS. The description must read "CMS/MMSEA patient complaint w/o".

6. The business office manager is responsible for ensuring all write offs for Medicare patients due to complaint of medical care are written off using code WO390.

7. The business office manager is responsible for obtaining approval from the administrator before writing off a Medicare patient balance due to complaints of medical care.

8. The business office manager is responsible for reporting all Medicare patient balance write offs due to complaints of medical care to Western Litigation Inc.

Section E: Definitions

Accounts Receivables (A/R) are the monies due to the facility for services rendered.

Application Period: The period during which NMOSC must accept and process an application for financial assistance under its FAP. The Application Period begins on the date the care is provided and ends on the later of the 240th day after the date of the first post-discharge billing statement for the care or at least 30 days after NMOSC provides the individual with a written notice that sets a deadline after which extraordinary collection actions (ECAs) may be initiated.

Bad debt is money the facility expected to collect and does not collect. Bad debt is that portion of an account, which is still outstanding, after reaching a specified age and reasonable efforts have been expended to collect.

Complaints of Medical care are complaints made by any patient specific to medical care received in any department of the facility.

Dunning letter is a request for payment sent to a patient. It is also called a collection letter.

Extraordinary Collection Action (ECA): includes any action taken by NMOSC against any individual related to obtaining payment of a bill for care covered under NMOSC's Professional, Employee, Self-Pay, and Charity Discounts policy, that requires a legal or judicial process or involves selling an individual's debt to another party or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

Section F: Connections

Part 1: Areas of Exposure

1. Inappropriate waiver of co-pay, deductible, and co-insurance.
2. Inappropriate waiver of facility fee.
3. Failure to follow state or federal collection laws.
4. Failure to make a reasonable attempt to collect from the guarantor.
5. Failure to report Medicare patient balance write offs due to complaints of medical care are fined by CMS at $1000.00 per day.

Part 2: Key Controls

1. The BOM and administrator approve bad debt write-offs.
2. Every effort is made to collect all Medicare co-pays, co-insurance amounts, and deductibles.
3. Collection efforts are made for all outstanding patient balances.
4. The BOM and administrator approve all Medicare patient balance write offs due to complaints of medical care.

Part 3: USPI's EDGE™ Connection

Getting paid fully and timely for services rendered

Part 4: Other Policies and Procedures

PAS 1.2.1 NM Professional, Employee, Self-Pay, and Charity Discounts

PAS 8.1 Credit Balance and Refund

PAS 9.3 Using Collection Agencies

Fair Debt and Collection Practices Act Internal Revenue Code Section 501(r)

Section G: Procedures

Part 1: Laying the Groundwork

1. The business office manager (BOM) provides the collector with a username and password for the PAS and reviews accounts making monthly payments periodically, to ensure that the accounts are fulfilling their agreements.

2. The facility retains the legal right to expedite payment at any time, for any reason, unless the facility has agreed to a repayment agreement with the guarantor, either verbally or in writing.

3. The BOM creates a facility write-off approval sheet to be used by the collector and approved by the administrator.

4. The administrator may refuse to schedule a case for a patient that has failed to fulfill their financial obligations on a prior date of service.

5. Services may be scheduled prior to making a request for financial assistance; however, a determination on the financial assistance application is generally required prior to obtaining services.

6. USPI suggests that the pursuit of the outstanding debt through appropriate channels should be weighed against the expected recovery amount.

Part 2: Patients with Out-of-Network Payors

If the facility granted a patient who had an out-of-network payor an in-network discount, the collector cannot attempt to collect the difference between gross charges and the payor allowed amount from the patient.

Part 3: Patient Statements - Creating in the PAS

1. The PAS may allow for a statement to be sent to patients, only after a third party payor has been paid and a canned message added to a patient's statement that has aged to a specific number of days.

2. A facility may use messaging that says the account "may" be referred to a collection agency. If the message says that the facility "will" turn the account over to a collection agency, the facility is required to follow through.

Part 4: Patient Statements - Generated and Mailed Monthly

1. On a monthly basis, at a minimum, the collector generates patient statements in the PAS, reviews each statement for complete address information, appropriate balances, etc., and mails the statement to guarantor.

2. A letter may be sent informing the patient that the insurance company has paid its portion and the remainder of the balance is the guarantor's responsibility.

3. A patient or carrier may at times request an itemized bill. In an ASC we will provide an itemization of the procedures performed and the billable implants and devices for the case. An ASC is not required to itemize supplies used since we global bill for procedures performed.

Part 5: Respond to Mail or Patient calls

1. The collector responds to mail from guarantors, documents the response in the PAS, files the guarantor's original correspondence with a dated copy of the facility's response in the correspondence file, and appropriately notes the patient's account in the PAS.

2. The collector responds to phone inquiries from patients and guarantors promptly. A record of the call and the resolution is noted in the comments for the patients account.

3. If statements or letters are returned as undeliverable, the collector attempts to locate the guarantor's correct address. If the correct address is located, the collector corrects the PAS and re-mails the item. If unable to locate the correct

address, the collector alerts the BOM, who forwards the account to a collection agency for skip tracing. A copy of the returned mail envelope is filed in the correspondence file.

4. If a change of address card arrives, the receptionist changes the address in the PAS.

5. If a patient contacts the facility with complaints of medical care, the administrator must be notified.

6. If the decision is made to adjust the remaining patient balance or refund prior payments, and the patient is a Medicare patient, who has lodged a complaint regarding medical care, CMS must be notified via Western Litigation Inc.

Part 6: Contacting the Guarantor

1. The business office manager (BOM) provides the collector training information on how to handle collection calls to guarantors in a variety of situations.

2. The collector documents all conversations and actions taken and places the results in the PAS.

3. Collectors are not legally required to advise the guarantor that their delinquent account is going to be referred to a collection agency if the facility has made previous requests or demands for payment in the form of an invoice, statement, dunning letter, completed financial agreement form, etc., unless required by state regulations.

4. The collector completes an adjustment form for accounts that need to be written off and/or sent to an outside collection agency and gives it to the BOM.

5. If payment from the guarantor is not received, the collector phones the guarantor to ask for the outstanding balance. If the guarantor reports she is unable to pay the full amount at once, the collector establishes a payment arrangement (i.e., promissory note) over the shortest possible time. See PAS 1.3 “Promissory Note” policy.

6. If a guarantor has an existing payment arrangement and defaults in any manner, the collector makes immediate demands for payment in full.

7. If the facility staff learns that the guarantor has died or has filed bankruptcy after the date of service, the collector informs the BOM who decides if the account should be filed with the court or written-off.

Part 7: Communication of the Financial Assistance Program (FAP)

1. NMOSC offers financial assistance for patients who meet the qualifications set forth in the PAS 1.2.1 NM Professional, Employee, Self-Pay, and Charity Discount policy. Patients may obtain a copy of the policy, financial assistance application, and a plain language summary of the FAP through the following ways:
   - Online at http://www.nmscortho.com
   - By contacting a customer service representative at (505) 291-2300
   - By mail, free of charge, upon request

2. Patients may submit completed financial assistance applications during a 240-day Application Period (as defined herein). NMOSC will not engage in any extraordinary collection action (ECA) against the patient or guarantor without making reasonable efforts to determine the patient's eligibility under the FAP policy. Specifically:

   - NMOSC will notify individuals about its FAP before initiating any ECAs to obtain payment for care and will refrain from initiating any ECA for at least 120 days from the first post-discharge or post-visit billing statement for the care.
   - If NMOSC intends to pursue ECAs, the following will occur at least 30 days before first initiating one or more ECAs:
     - NMOSC will notify the patient in writing that financial assistance is available for eligible individuals and will identify the ECAs that may be initiated to obtain payment. This written notice will include a deadline after which such ECAs may be initiated that is no earlier than 30 days after the date that the notice is provided;
     - The above notice will include a plain language summary of the FAP;
     - NMOSC will make a reasonable effort to notify the patient verbally about the FAP and how the individual may obtain assistance with the application process.
     - If NMOSC combines a patient's outstanding bills for multiple episodes of care before initiating one or more ECAs, it will refrain from initiating the ECAs until 120 days after it provided the first post-discharge billing statement for the most recent episode of care.

Part 8: Processing FAP Applications

1. If an individual submits an incomplete FAP application during the Application Period, NMOSC will:
   - Suspend any ECAs; and
   - Provide the individual with a written notice that describes the additional information and/or documentation required under the FAP or FAP

application form that must be submitted to complete the application. This notice will include the NMOSC contact information set forth in this policy.

2. If an individual submits a complete FAP application during the Application Period, NMOSC will:
   - Suspend any ECA previously initiated;
   - Make an eligibility determination as to whether the individual is FAP-eligible for the care and notify the individual in writing of the eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination.

3. If the individual is determined to be FAP eligible for the care, NMOSC will:
   - Provide the individual with a written notification that indicates the amount the individual owes for the care under the FAP, how that amount was determined and how the individual can get information regarding the AGB for the care.
   - Refund to the individual any amount he or she paid for the care that exceeds the amount he or she is determined to be personally responsible for paying under the FAP, unless such excess amount is less than $5 (or such other amount published in the Internal Revenue Bulletin).
   - Take all reasonably available measures to reverse any ECA (with the exception of a sale of debt) taken against the individual to obtain payment for the care.

4. In the event no FAP application has been submitted during the Application Period, NMOSC may initiate ECAs to obtain payment for the care once it has notified the individual about the FAP as described in Part 7 of this policy.

Part 9: Billing Dispute and Resolution:

1. Collection activity will be suspended when a patient disputes the balance. NMOSC will review, document and research the account for prompt resolution. Any corrections will be made immediately, accounts will be returned from collections, and adverse reporting removed as appropriate. Collection activities will resume on outstanding balances that are determined to be valid in accordance with the Fair Debt and Collection Practices Act.

2. Patients may dispute their balance by calling (505) 291-2300 or by written communication to:

   NEW MEXICO ORTHOPAEDIC SURGERY CENTER
   8300 CONSTITUTION AVE NE
   ALBUQUERQUE, NM 871107613

Part 10: Write-Off to Bad Debt - Balance

1. The account balance may be written off to bad debt when:

    a. Reasonable efforts by collectors (filed claim and followed up with third party payor attempts to collect from the guarantor) have failed to collect the amount. The standard collection attempt is 3 statements.
    b. Notice of discharge from the court for bankruptcy is received.
    c. A guarantor has not rectified a missed, late, or short payment during the agreement period.
    d. There is evidence the account is uncollectable (guarantor has skipped, died, or filed bankruptcy).
    e. When the cost of the collection effort outweighs the amount to be collected.
    f. The balance has aged more than 120 days.
    g. The account is 12 months past the date of service.

2. The collector completes the facility's write-off sheet and gives it to the BOM.

3. The BOM reviews the sheet from the collector and determines if the account meets criteria for write off or collection agency action.

4. The BOM enters the appropriate transaction into the PAS as well as comments if the account is placed with an outside agency. Comments should include when it was placed which agency it was given to, and what amount was turned over.

5. The administrator approves the accounts that are to be written-off to bad debt by either signing the report from the PAS listing each account or approving the email from the BOM or CBO Director. Copies of the approval need to be kept with all other internal control monthly documents.

Part 11: Write-Off to Bad Debt - Small Balance

1. The collector reviews accounts with a debit balance of $9.99 or less prior to month-end close procedure.

2. For guarantor accounts with debit of $9.99 or less, the collector can write-off the difference, so the account is at $0.00 by using the appropriate "small balance

write-off" code for the PAS. A small balance write-off does not require approval from the administrator or BOM.

Part 12: Medicare Patient Balance Write-Off to CMS/MMSEA

1. The account balance may be written off to CMS/MMSEA when:

    a. Patient complaint is received regarding their **medical care**.

    And

    b. **Administration is contacted and deemed the complaint to be valid**.

2. The collector completes the facility's write-off sheet and gives it to the BOM.

3. The BOM reviews the sheet from the collector and determines if the account meets criteria for write off. If approved, the adjustment form is given to the administrator for approval or an email is sent to the administrator from the CBO director.

4. The administrator approves the written-off by signing the adjustment form or email from the CBO director. Copies of the approval need to be kept with all other internal control monthly documents.

5. The BOM immediately reports all accounts to Western Litigation, Inc.

6. The BOM enters the appropriate transaction into the PAS as well as comments as to when it was reported to Western Litigation Inc.

Part 13: Sanctions

Penalties for violation of this policy will vary depending on the nature and severity of the violation. Individuals who violate the above will be subject to disciplinary action up to and including termination; legal action by USPI, including but not limited to, criminal prosecution under appropriate state and federal laws; and providing restitution for improper use.

Part 14: Audit

1. The business office manager reviews all PAS write-offs and adjustments for validity at least monthly.

2. The center accountant and operating management reviews A/R aging reports and write-off percentages for reasonableness, as part of a monthly operating

review. If results are not consistent with expected results, further investigation is performed.

3. The internal auditor evaluates propriety of account history and attainment of approvals for accounts written-off to bad debt and CMS/MMSEA due to patient complaints of medical care

Section H: Revision History

Date	Revision Number	Change	Revised Sections
03/01/20	1.0	New document	N/A