MEDICAL CENTERS: PATIENT ACCOUNTS RECEIVABLE

Contents

Contents (Cont.)

MEDICAL CENTERS: PATIENT ACCOUNTS RECEIVABLE

I. INTRODUCTION

Patient accounts receivable represent amounts owed to the medical center patients or by third party payors (sponsors) for services rendered. Patient accounts receivable are generally the largest item in the current asset section of the balance sheet. The accounts receivable cycle begins with the delivery of service (creation of an account receivable) and extends to receiving cash for services rendered (collection), estimating accounts which may not be collected (adjusting), and recognizing that a particular account is not collectible (write-off).

Each of these economic events affects the accounting system. Therefore, each medical center is responsible for maintaining a system for establishing individual patient accounts, recording patient charges in those accounts, and processing patient bills/claims from those accounts. The details of the individual patient accounts and bills are recorded in this system and updated on a timely basis to reflect new charges, allowances granted, cash received, refunds, and write-offs of uncollectible amounts. The system must provide monthly summaries of all transactions for entry in the University's General Ledger control account for patient accounts receivable, and the detail in the medical center system should be reconciled monthly to the control account.

II. PROCEDURES

A. FINANCIAL EVALUATION

A primary financial class, sometimes referred to as an insurance code or sponsorship, is assigned to the patient at the time of preadmission or admission. This primary financial class indicates the type of health plan, if any, under which the patient has medical coverage. Examples include Medicare, Medi- Cal, county, commercial insurance, workers'

II. PROCEDURES (Cont.)

A. FINANCIAL EVALUATION (Cont.)

compensation, self-pay, or medically indigent. In addition to a primary financial class, most patients will be assigned a secondary financial class, which indicates the responsibility for charges not covered by the primary payor. As soon as the patient is registered, the admitting office shall transmit the information to the billing section. Proper identification of the financial class is a key element in the patient billing system.

It is an integral part of the financial evaluation function to attempt to obtain a deposit from the patient at the time of admission. The deposit should be an approximation of what the patient will ultimately have to pay from his/her own personal resources. At the time of discharge, the patient should be required to settle any remaining personal indebtedness either with cash, an approved credit card, or an agreed-upon schedule of installment payments that will result in the earliest possible final settlement of the account.

B. DISTINGUISHING BETWEEN BAD DEBT AND CHARITY CARE

Sound management concepts require that bad debts be distinguished from charity care so that medical center management can draw informed conclusions as to the effectiveness of its collection efforts and the extent to which medical center resources are being used in caring for those patients unable to pay for services. It is essential that medical center management not only distinguish bad debts from charity care, but also establish a charity care policy that complies with the revisions to the American Institute of Certified Public Accountants' (AICPA) Audit and Accounting Guide for Health Care Organizations and the State of California's Tobacco Tax Initiative (Proposition 99) and subsequent implementing legislation.

The following University-wide guidelines provide for qualifying and reporting accounts as bad debt or charity care:

1. Definitions

The distinction between bad debt and charity care is the unwillingness of the patient to pay versus the demonstrated inability of the patient to pay. Applying this distinction is achieved by

determining the financial status of an individual patient.

A bad debt results from services rendered to a patient who is determined by the medical center, following a reasonable collection effort, to be able but unwilling to pay all or part of the bill.

Charity care results from services provided to individuals who are unable to pay. A charity patient is a person who is determined by the medical center to be unable to pay for medical or medical center care, or a person who exhausts personal resources and third-party coverage during his or her medical center stay.

2. University-wide Guidelines for Charity Care

a) Each medical center shall establish eligibility criteria, financial screening, and means testing procedures for determining charity care.

b) The medical center's charity care policy should reflect the medical center's mission statement.

c) Every effort should be made to classify patients at the time of admission, or at the time of registration, or as soon as possible thereafter as charity (full or partial) or as paying patients.

d) The medical center's charity care policy shall be applied consistently.

II. PROCEDURES (Cont.)

B. DISTINGUISHING BETWEEN BAD DEBT AND CHARITY CARE

2. University-wide Guidelines for Charity Care (Cont.)

e) Each medical center should develop procedures to ensure that compliance with its charity care policy is documented and appropriate approvals are obtained.

f) The medical center's policy on charity care eligibility should specify those services which may not be written off as charity care.

g) Appropriate factors, based on local conditions, should be established in determining the criteria for charity care eligibility. The factors used should be reviewed regularly and updated as appropriate.

h) The criteria for establishing the ability to pay should include recognition of the impact of events subsequent to the admission that may change the patient's ability to pay, e.g., medical complications that dramatically increase the cost of services, or a substantial change in the patient's financial status. Therefore, events such as catastrophic hospitalization costs may result in retroactive eligibility for charity care or in extending charity care to patients not meeting all of the criteria established by the medical center during the initial screening.

i) To the extent that it is practical and possible, appropriate financial documentation should be collected from the patient as part of the financial screening procedure to determine the patient's eligibility for charity care. If the above documentation is not available the patient's signature, whenever possible, should be obtained to certify that the information contained in the screening document is accurate and complete. If the patient attests to the accuracy and completeness of the screening document by telephone, a dated note should be attached to the screening document. The appropriate documentation should be maintained on file to meet audit

requirements. In the event that it is not possible to acquire the appropriate financial documentation, the patient's eligibility for charity care may be determined based upon other information available to the medical center.

j) Procedures used for financial screening and means testing should specifically enumerate the sources of income which will be used as the basis of eligibility.

k) Patients should report to the medical center any change in their financial condition.

l) Patients who are potentially eligible for assistance through state, county, and other public funded programs should be advised of these programs before the account is charged to charity care.

m) The medical center should provide its charity care policy to its collection agency because accounts that may be eligible for charity care can be referred to a collection agency for additional information to determine a patient's eligibility. When the agency has determined that a patient's account, in whole or part, is eligible for charity care, it should notify the medical center.

3. Recording and Reporting

The amount of bad debts should be recorded as an estimate based on several generally accepted methods; whereas, charity care should be recorded

II. PROCEDURES (Cont.)
B. DISTINGUISHING BETWEEN BAD DEBT AND CHARITY CARE (Cont.)
3. Recording and Reporting (Cont.)

at the actual amounts written off and not the expected level of charity to be provided.

Charity care write-offs shall be reported as teaching allowances in the Monthly Financial Statement. In the Hospital Annual Financial Report, charity care will be disclosed in a footnote but will not be reflected on the Statement of Revenue and Expense.

C. PREPARATION OF BILLS

1. Recording and Reviewing Patient Charges

All revenue generating centers are responsible for ensuring the timely and accurate submission of individual charge transactions into the billing system. In the preparation of input documents, attention must be given to legibility and completeness of required data so that the documents can be promptly processed. Appropriate audit trails and controls must be maintained. All charges are to be recorded in full, even though specific allowances might subsequently be applied to individual accounts.

Charges or credits should be submitted no later than two business days following service so that accounts are kept up-to-date and complete final bills can be prepared. If late charges per individual account exceed an individual medical center's defined parameter, a supplemental bill should be processed. If late charges are not processed for payment, they should be recorded in the appropriate medical center's account (e.g., allowances, charity, bad debt, etc.).

To provide assurance of the on-going effectiveness of individual departmental charge systems, the following minimum medical center-wide controls should be implemented:

a) Charges received after the deadline of two business days should be monitored. A late charge report should be prepared monthly and sent to the appropriate department heads.

b) Periodic reviews for unbilled and unsupported charges should be conducted by a person with

sufficient knowledge of charging and chart documentation procedures using agreed-upon criteria or targets established between the administration and the department(s). The reviewer should compare a sample of final bills with related medical records to identify unbilled and unsupported charges. The results of the review of unbilled and unsupported charges, and any significant trends in departmental late charges, should be reported at least annually to the department(s) and to the Medical Center Finance Director, who shall work within the administrative structure of the medical center to ensure that departments develop corrective action plans when appropriate.

2. Billing Accounts

All in-house accounts should be reviewed and pertinent information updated on an ongoing basis. In addition, an estimate should be made--at the earliest date possible--of the amount of liability the patient will have when discharged. After discharge, the patient account is normally kept open to allow for late charges. Reviews of the itemized bill shall be made to determine whether the charges appear reasonable for the diagnosis. The initial billing should be followed up with a second bill within a specified time determined under medical center policy. This procedure should apply to third party payors as well as to self-pay accounts.

II. PROCEDURES (Cont.)

D. ANALYSIS OF ACCOUNTS

Each medical center will maintain the detail of its individual accounts receivable in a manner that provides information as to the age of the accounts. The following aging categories must be maintained 0-30, 31-60, 61-90, 91-120, and over 120 days. Accounts will continue to be aged until paid in full or until written off. Inpatient accounts will be aged from the date of discharge, regardless of the date the final bill is issued. At the psychiatric medical centers, both inpatient and outpatient accounts will be aged from the date of interim billing.

Charges to individual outpatient accounts will be grouped by billing cycles and the accounts aged accordingly, with cash payments being applied to the oldest group first, excluding those payors who specifically designate otherwise.

In addition, each medical center will maintain records that show the breakdown of unbilled accounts between charges relating to in-house patients and charges relating to discharged patients for whom final bills have not been prepared. Records reflecting the length of time between the preparation of the final bills and the mailing of the resulting claims to the appropriate third-party sponsors should also be maintained.

Within all these categories of accounts, the bills are to be identifiable by primary payors or primary responsibility for payment. Each medical center should establish procedures for changing payor identification on individual accounts whenever there is a change in the primary responsibility for payment of the outstanding balance.

Each medical center should maintain as many payor categories as are needed. For reporting purposes to the Office of the President (OP), the payor categories shall be grouped into the following major categories:

1)	Medicare: (Non-Risk)	All patient services paid by the Medicare fiscal intermediary, under Title XVIII of the Social Security Act, excluding Medicare risk patients.
2)	Medicare: (Risk)	Medicare patients who have their health care covered by Medicare capitated contracts.
3)	Medi-Cal: (Non-Risk)	All patient services paid by the Department of Health Services fiscal intermediary, under Title XIX of the Social Security Act, modified by Assembly Bill 799. In addition to those patients who are identified as Medi-Cal patients at time of discharge, this category includes those patients identified as Medi-Cal pending and Medicare Part B/Medi-Cal crossovers at time of discharge. This category excludes Medi-Cal risk patients.
4)	Medi-Cal: (Risk)	Medi-Cal patients who have their health care covered by Medi-Cal capitated contracts.
5)	County:	All patient services covered under County contracts, including the following: --Medically Indigent Services (MIS) patients --Custodial patients --County patients from other counties, other than MIS patients --Welfare and Institutions Code, section 17000 patients --County Medical Services Program (CMSP) patients and other county MIS patients

II. PROCEDURES (Cont.)

D. ANALYSIS OF ACCOUNTS (Cont.)

6) Commercial Insurance: Charge-based, third party payers, (Fee-for- i.e., commercial insurance and Service) Workers' Compensation[1].

7) Contracts: For patient services covered under (Discounted contractual arrangements excluding or Per-Diem) the ones previously mentioned. Included in this category are: Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Health Maintenance Organizations (HMO), Veterans' Administration (VA)medical center contracts, Champus, California Children Services (CCS), grants, Workers' Compensation[2], and out of state Medicaid patients.

8) Contracts: Patient services under full or (Capitated) significant partial financial risk contracts (i.e., commercial, as well as, county medical services patients treated at the Irvine and San Diego Medical Centers).

9) Non-Sponsored/Self-Pay: For patient services not covered under any formal insurance plan, e.g., self-pay, cash package pricing and non-pay patients.

Appendix I contains a table to be used when reporting information by payor.

E. COLLECTION AND REFUND

Each medical center must establish documented and supervised collection control procedures and maintain records of collection efforts showing date and type of follow-up, response, and subsequent action. Further, special procedures are to be established for handling accounts when a possible malpractice suit is indicated, (i.e., the accounts should be flagged and submitted to Risk Management for review).

Each month, all patient receivable accounts that have become 90 days old must be reviewed and necessary follow-up action performed, including dunning letters

[1] Insurance carriers that pay full charges for Worker's Compensation cases will continue to be reported in the Commercial Insurance category but insurance carriers that pay for Worker's Compensation cases at negotiated rates will be reported in the Contract category.

[2] See footnote 1.

and telephone calls as appropriate. At the conclusion of the effort, accounts for which no collection has been effected, including the documentation covering the collection effort thus far exerted, will be reviewed by responsible personnel to determine the extent of further collection efforts.

If it is determined that additional follow-up is not likely to result in collection of an account, the account may be referred to the Office of the General Counsel or turned over to a collection agency. The Exhibit at the end of this chapter states the criteria to be followed when seeking collection assistance by the Office of the General Counsel. Any medical center bad debt account meeting the criteria stated in the Exhibit should be sent directly to the General Counsel. If General Counsel cannot be of any assistance, the account should be returned to the medical center and written off at the campus level if the amount involved is under the dollar limit requiring Regental approval. Accounts requiring Regental approval for write-off should be returned to Hospital Accounting in OP where a Regents' item will be prepared. Each medical center must maintain detailed records and control data on all accounts placed with a collection agency and periodically reconcile these records with the agency's records.

Procedures which assure timely follow-up of third party sponsored accounts should also be established as appropriate.

Another integral aspect of the collection effort is the review and disposition of credit balances. Each medical center must establish procedures which ensure that each patient account showing a credit balance is analyzed monthly to determine whether cash payments and clinical teaching support funds have been properly applied to the account.

II. PROCEDURES (Cont.)

E. COLLECTION AND REFUND (Cont.)

Patient refunds result when a bill is overpaid, due in part to supplemental insurance coverage or overpayment of the coinsurance or deductible portion of the medical center bill. The first task in an overpayment situation is to search the accounts receivable records to determine whether the patient has another account with the medical center. If there is a possibility that the patient had an account that was written off, a search of prior bad debt expense should be made. If there is any other account to which the credit balance can be applied, the medical center should assume the right to offset. If the overpayment resulted because more than one insurance company paid for the medical center service, the medical center may be required to refund the overpayment to one of the insurance carriers. After it has been determined that there is no other account, the overpayment must be refunded promptly under established University disbursement procedures.

F. UNCOLLECTIBLE ACCOUNTS

1. Allowance For Uncollectible Accounts

Whenever services are rendered, it must be recognized that some accounts will never be collected. To match the revenues and expenses of a given period and to value outstanding patient receivables properly, a provision must be made to record the estimated amount of patient accounts that cannot be collected. Each medical center will maintain a valuation account entitled "Allowance for Uncollectible Accounts." This account will be credited as a contra account for the monthly provision to be deducted from revenue.

The monthly provision for Bad Debts may be calculated by (1) applying a percentage, based on local past experience, to gross patient revenue, or (2) applying appropriate percentages, based on local past experience, to aged categories of

outstanding receivables debit balances at the end of the accounting period. The current provision will be the amount necessary to increase the allowance account to the required level. Option (2) may be used as often as considered necessary but no less often than semi-annually, including at fiscal year-end. Any change in methodology, or in the percentages used, that produces a significant change in the provision must be explained in the narrative section of the monthly Statement of Operations.

2. Writing Off Uncollectible Accounts

Uncollectible accounts will be written off, subject to appropriate approval authority, when they are determined to be uncollectible or when they are placed with a collection agency. The Allowance for Uncollectible Accounts will be charged for the amounts to be written off; the University General Ledger accounts receivable control will be credited with the corresponding amounts, and the detail of the individual accounts will be removed from the medical center billing system. Complete records of all accounts written off will be maintained.

Authority to approve the write-off of bad debt amounts on patient accounts, provided funds are available for that purpose, has been delegated to
** the Chancellors and the Senior Vice President--Business and Finance.[3]

When write-off approval by the Senior Vice President--Business and Finance is requested, pertinent information must be provided to Hospital Accounting in the Office of the President so that the account(s) can be formally

[3] At their meeting on July 14, 1993, The Regents approved a change in Standing Order 100, Section 100.4(2), authorizing the President to write off bad debts, provided reserves for that purpose are adequate or that specific income or an appropriation is available for that purpose. On December 22, 1993, the President delegated this
** authority to the Chancellors and Senior Vice President--Business and Finance. Any redelegation of this authority shall be in writing with copies to the Coordinator-Universitywide Policies, the General Counsel and Vice President for Legal Affairs, and the Secretary of The Regents.

II. PROCEDURES (Cont.)
F. UNCOLLECTIBLE ACCOUNTS (Cont.)
2. Writing Off Uncollectible Accounts (Cont.)

submitted to the Senior Vice President for approval.

When submitting an account for write-off approval to the Senior Vice President, the following details about the account must be included:

a) date of admission (first admission);
b) date of discharge (last discharge);
c) total patient charges;
d) amount being written off; and
e) reasons for write-off:

1) Maximum collection effort expended--referral to a collection agency. Where applicable, include a statement that additional information obtained by the collection agency may result in this account being reclassified as charity care.

2) Maximum collection effort expended--no referral to a collection agency. (Include a brief description why account was not referred).

3) Other (provide explanation).

* A bad debt account that is to be written off will be processed for write-off authority in the month received as long as the account is received by Hospital Accounting in the OP seven working days before the end of the month.

Patient Account Managers will be notified in writing whether their medical center's request to write-off a bad debt account was approved by the Senior Vice President--Business and Finance.

Receivables not approved for write-off will remain in the medical center billing system and

the University General Ledger. Accounts may not be referred to a collection agency until after receiving write-off approval by the Chancellor or by the Senior Vice President--Business and Finance.

3. Recoveries

Recoveries on accounts written off will be credited back to the Allowance for Uncollectible Accounts. When collection is effected by a collection agency, the total amount collected by the agency is to be credited to the allowance account and the agency's commission is to be recorded as an operating expense captioned "Collection Agency's Expense."

4. Collection Agencies

A competitive bidding process must be conducted before an account or group of accounts is referred to a collection agency and the expenditure (e.g., commission) for the collection
* services will amount to more than $50,000 annually. The request for quotation will include specifications determined by the medical center director, or his/her designee, to ensure optimal collection performance. On refusal or failure of the lowest responsible bidder to execute an awarded contract, the contract may be awarded to the second lowest responsible bidder if such award is in the best interest of the University. Similarly, if the second lowest responsible bidder fails or refuses to execute the contract, such contract may be awarded to the third responsible bidder.

In case of doubt or question on referral of accounts to collection agencies, especially in matters involving competitive bidding, the advice of General Counsel should first be sought.

An agreement between the medical center and the collection agency for collection services should

II. PROCEDURES (Cont.)
F. UNCOLLECTIBLE ACCOUNTS (Cont.)
4. Collection Agencies (Cont.)

be in writing. Included in the agreement should be a requirement that the collection agency report collection progress at least quarterly. The medical center should regularly review the performance of its collection agencies.

Accounts should be considered for assignment to a collection agency as soon as the collection effort specified in section II.D of this chapter has been completed. Unless there is evidence of a good faith intention to pay, an uncollected account should be referred to a collection agency no later than 180 days after the date the patient's proper liability has been determined. Periodically, the medical center should reconcile its records with the collection agency's records of accounts.

** III. CREDIT BALANCE REFUNDS

Patient refunds result when a bill is overpaid due, in part, to supplemental insurance coverages or overpayment of the coinsurance or deductible portion of the medical center bill.

GENERAL PROCEDURES FOR UNCLAIMED PROPERTY (Credit Refunds)

A. DETERMINE THE CAUSE OF THE CREDIT BALANCE

1. Each medical center must establish procedures which ensure that each patient account showing a credit balance is analyzed monthly, or as soon as possible, to determine whether cash payments and clinical teaching support funds have been properly applied to the account.

B. INITIAL RESEARCH OF THE CREDIT BALANCE

1. The accounts receivable records should be searched to determine whether the patient has another account with the medical center.

2. If there is a possibility that the patient had an account that was written off, a search of prior bad debt expense should be made.

3. If there is any other account to which the credit balance can be applied, the medical center should assume the right to offset.

4. After it has been determined that there are no other patient accounts, the overpayment must be refunded promptly under established University disbursement procedures.

5. If the overpayment resulted because more than one insurance company paid for the medical center service, the medical center may be required to refund the overpayment to one of the insurance carriers, Note: If it is determined that the refund is to Medicare, the refund must be made within 60 days of the credit balance appearing on the account. (Title 42 of the Code of Federal Regulations Part 489.20(h) states: "If the provider receives payment for the same services from Medicare and another payor that is primary to Medicare, the provider is to reimburse Medicare any overpaid amount within 60 days.")

C. INITIATE THE REFUND PROCEDURE

In some cases, the duplicate adjustments or payments and adjustments can cause a credit. The account should be reviewed to determine if the adjustment can be reversed.

1. Before refunding an overpayment to the patient, verify the payor to ensure that the refund is being made to the correct party (i.e., proper name and address). The payor is not always the patient.

2. Patient refunds under $25 should not be refunded unless requested by the payor.

** III. CREDIT BALANCE REFUNDS (Cont.)

C. INITIATE THE REFUND PROCEDURE (Cont.)

3. No adjustments should be made to any account with a patient credit balance until a response has been received or there is no response after 45 days of sending a letter (attached).

4. Patient payment made by credit card must be credited back within one year of receipt to the same credit card account. After one year, a check should be issued.

5. All refunds should be approved by a supervisor.

D. ATTACH THE NECESSARY SUPPORTING DOCUMENTS

The following supporting documentation should be attached to the refund:

1. An explanation stating the reason for the refund and any other pertinent information.

2. Copies of payment checks when there was an overpayment or erroneous overpayment.

E. ACCOUNTING PROCEDURES FOR CREDIT BALANCES

1. Overpayment Refunded to Third-Party or Patient

Dr. Patient Accounts Receivable
Cr. Cash

2. Credit Balance recorded on Hospital Financial Statements

Dr. Patient Accounts Receivable
Cr. Other Liabilities

3. Overpayment Applied to Outstanding Balances

Dr. Patient Accounts Receivable
Cr. Patient Accounts Receivable

IV. RESPONSIBILITIES

A. CHANCELLORS AND MEDICAL CENTER DIRECTORS

Chancellors and medical center administrative officers have the responsibility to ensure that the procedures set forth in this chapter are uniformly and consistently applied and followed by their respective campus medical centers and health care facilities. They may delegate adequate authority to their respective medical center finance officers for purposes of implementing the procedures set forth in this chapter.

B. MEDICAL CENTER FINANCE OFFICERS

Medical center finance officers, in consultation with their respective campus accounting officers and/or the Director--Financial Management, OP, as necessary, are responsible for the local application of the procedures set forth in this chapter. Further, they will ensure that patient accounts receivable accounting is performed in keeping with governmental health care facility coordinating or regulatory agencies, such as the Office of Statewide Health Planning and Development (OSHPD).

V. REFERENCES

Assistant Counsel Moore, Letter to Coordinator Scott on Contracts with Collection Agencies--Competitive Bidding Requirements, December 13, 1978.

Vice President Lamson, Letter to Acting Assistant Vice President Pastrone on Write Off of Bad Debts, April 21, 1980.

Acting Assistant Vice President Pastrone, Letter to Assistant Chief Accountant Alter on Write Off of Bad Debts, May 27, 1980.V.

Vice President Brady, Letter to University Controller Pastrone on Confirmation of Authority--To Write Off Bad Debts, April 11, 1983.

V. REFERENCES (Cont.)

President Gardner, Memorandum to Chancellors and Vice President Brady on Delegation of Authority--To Write Off Bad Debts, June 10, 1987.

Vice President Brady, Memorandum to Chancellors on Limit for the Write Off of Bad Debts, August 12, 1992.

President Peltason, Memorandum to Senior Vice President--Business and Finance, July 30, 1993.

Coordinator Turek, Memorandum to Medical Center Finance Directors, August 8, 2005.

Accounting Manual chapter:

C-173-78 Cash: Unclaimed and Uncashed Checks

H-576-12 Medical Centers: Accounting for Capitated Contracts

R-212-2 Receivables Management

Business and Finance Bulletins:

BUS-43 Materiel Management: General Requirements for Common Goods, Materials, and Services Over $50,000 in Value.

Historical note: Chapter first published 7/1/69. Revised 5/1/88, 12/1/92, 12/30/93, 6/30/99, 6/30/06, and 3/31/07; analyst--John Barrett.

APPENDIX I: Information Reporting by Payer

UNIVERSITY OF CALIFORNIA
TEACHING HOSPITALS'
COMPARISON OF CURRENT YEAR-TO-DATE TO PRIOR YEAR-TO-DATE
PATIENT DAYS BY SPONSOR, GROSS REVENUE & NET REVENUE BY FUNDING SOURCE
JUNE 30, 20XX
($ in thousands)

	Gross Revenue		Revenue Deductions		Net Revenue		Net Revenue - Inpatient		Net Revenue - Outpatient	
Medical Center's Name	Current Year	Prior Year	Current Year	% (d)	Current Year	Prior Year	Current Year	Prior Year	Current Year	Prior Year
Medicare (non-risk) (a)	$ %	%	$	%	$ %	%	$ %	%	$ %	%
Medicare (risk) (a)	%	%		%	%	%	%	%	%	%
Medi-Cal (non-risk) (b)	%	%		%	%	%	%	%	%	%
Medi-Cal (risk) (b)	%	%		%	%	%	%	%	%	%
County (c)	%	%		%	%	%	%	%	%	%
Commercial Insurance (fee-for-serv)	%	%		%	%	%	%	%	%	%
Contract (discounted or per-diem)	%	%		%	%	%	%	%	%	%
Contract (capitated)	%	%		%	%	%	%	%	%	%
Non-Sponsored/Self-Pay	%	%		%	%	%	%	%	%	%
Total/Subtotal	%	%	$	%	%	%	%	%	%	%
CTS	%	%			%	%	%	%	%	%
Other Op. Rev.	%	%			%	%	%	%	%	%
Total	$ %	%			$ %	%	$ %	%	$ %	%

(a) Medicare disproportionate share payments are applied to Medicare - non-risk patients.
(b) SB 855, SB 1255 and SB 1732 Funds shall be applied to both Medi-Cal - risk and non-risk inpatients based on the percentage of gross inpatient revenue.
(c) County payments shall include "County Tobacco Tax Funds" which shall be recorded as an off-set to Coun
(d) The percentages reflect the relationship of Revenue Deductions to Gross Revenue.

	Patient Days		Outpatient Visits	
Medical Center's Name	Current Year	Prior Year	Current Year	Prior Year
Medicare (non-risk)	%	%	%	%
Medicare (risk)	%	%	%	%
Medi-Cal (non-risk)	%	%	%	%
Medi-Cal (risk)	%	%	%	%
County	%	%	%	%
Commercial Insurance (fee-for-serv)	%	%	%	%
Contract (discounted or per-diem)	%	%	%	%
Contract (capitated)	%	%	%	%
Non-Sponsored/Self-Pay	%	%	%	%
Total/Subtotal	%	%	%	%

EXHIBIT A: Accounts Receivable--Collection Assistance by Office of the General Counsel

OFFICE OF THE GENERAL COUNSEL
300 UNIVERSITY HALL
BERKELEY — EXTENSION 2-2822

RECEIVED
OCT 30 1984
SENIOR VICE PRESIDENT-
ADMINISTRATION

Please Refer to File No.

October 26, 1984

CHANCELLORS

Re: Accounts Receivable - Collection Assistance by Office of the General Counsel

Dear Colleagues:

Effective immediately, accounts over $15,000 which would otherwise have been referred to the Office of the General Counsel for collection assistance pursuant to my December 20, 1982, and earlier memoranda should be assigned for collection to agencies with which the campus or hospital has existing arrangements for collection of other, lesser value accounts.

This action is taken because of changes in workload patterns within this office and our determination that our effort can be more productively applied in other areas. Generally, collection matters are fairly routine in character and collection agencies and their counsel can deal quite effectively even with higher value accounts. For the most part, those accounts over $15,000 which have been referred to us have been hospital accounts. In our review of this proposal with hospital finance directors at Irvine, UCLA, and San Francisco, the consensus is that handling of such matters by collection agencies will not present problems. Notwithstanding this action, the Office of the General Counsel will remain available for:

1. legal advice generally with respect to the legal aspects of collection activity and practices;

2. matters where a collection agency has refused to accept assignment of an account;

3. unusual situations involving sensitive relationships or matters of significant University or hospital policy where internal control and management of collection litigation is essential;

4. accounts where the debtor files a cross complaint; and

EXHIBIT A: (Cont.)

CHANCELLORS
October 26, 1984
Page 2

5. circumstances where appeal of a small claims judgment is involved.

My recommendation is that appropriate campus personnel contact the agencies to whom you would propose to assign over $15,000 accounts with the request that they contact Managing University Counsel John Lundberg for assignment of matters currently pending within this office meeting the criteria for assignment to collection agencies. Mr. Lundberg will be prepared to work with counsel for the agencies in substituting counsel on currently pending cases. In addition, existing agreements or with instructions to collection agencies should be amended to require that any matter in which a cross complaint is filed shall be referred to this office.

If a debtor is the subject of bankruptcy proceedings, accounts should continue to be referred to Nancy Bengston, Office of the Senior Vice President - Academic Affairs, 2000 Hearst Avenue, Berkeley, for processing of the necessary claim forms.

If you have questions, please contact Mr. Lundberg.

Sincerely,

Donald L. Reidhaar
General Counsel

cc: R. Brady
D. Gardner
C. Hopper
W. Gonzalez
W. Kerr
F. Loge
R. Schultze
M. Stringer
F. Amini
D. Rockwell

** EXHIBIT B:Address Verification

Date:

RE: Address Verification

Patient Name: Account #:

To:

Dear _____:

The Medical Center is currently attempting to process a refund that we believe is due to you. Before mailing the refund, we must confirm your current address to assure that the refund reaches you. If the address listed above is correct, please sign in the space indicated below. If your address has changed, enter your new address under option # 2 below. Return this letter to us in the enclosed, postage-paid envelope.

Sincerely,

Medical Center
Patient Financial Services

1. I confirm that the address is still valid.

   Signature_____

2. My address has changed. Please send the refund to me at the following address:

   _____
   Number and Street

   _____
   City, State & Zip Code

   Telephone Number: ( ) _____

** EXHIBIT C:Claim Adjustment Inquiry

Date:

Patient Name:	
Service Date:	Account #:
Insured Name:	ID #:
Group #:	Claim #:
Payment Amount Received:	

Dear Claims Manager:

It has come to our attention that the above referenced claim may have been processed at an incorrect contractual rate. Please review the claim to determine if an adjustment needs to be made.

If you feel you are due a refund, please respond within 30 days of this letter. Send your request in writing to:

Appropriate Medical Center Department
Address of the Medical Center

Your attention to this matter is appreciated.

Sincerely,

MEDICAL CENTER
Patient Financial Services

End.