Change Page

Section 2.7.f -- Collection and Write-off of Accounts Receivable

REVISION DATE	CHANGE NUMBER	CHANGE
3/23/2011	1	**Click here for red letter edition**
09/30/2003	1	**PROCEDURE, New Item 1:** An attempt to collect will always be made at the time the service is rendered and a statement does not need to be mailed to the patient. This will serve as the first collection attempt. **Change Reason:** Resulted from changes in the F&A rule and policy 0620-1-9 pertaining to Accounts Receivable
	2	**PROCEDURE Item 2: Change:** If the balance of an account is below $75, at least one (1) collection effort is required. **To:** If the balance of an account is below ~~$75~~ $25, at least one (1) collection effort is required. **Change Reason:** Resulted from changes in the F&A rule and policy 0620-1-9 pertaining to Accounts Receivable
	3	**PROCEDURE Item 3: Delete:** However, if the balance of the account is below $10, and an attempt to collect was made at the time the service was rendered, a statement does not need to be mailed to the patient. **To:** ~~However, if the balance of the account is below $10, and an attempt to collect was made at the time the service was rendered, a statement does not need to be mailed to the patient.~~ **Change Reason:** Resulted from changes in the F&A rule and policy 0620-1-9 pertaining to Accounts Receivable
	4	**PROCEDURE Item 3: Change:** Any account with a balance of $75 or more requires three (3) documented collection efforts. **To:** ~~Any account with a balance of $75 or more requires three (3) documented collection efforts.~~ If the balance of an account is between $25 and $49.99, at least two (2) collection efforts are required. **Change Reason:** Resulted from changes in the F&A rule and policy

		0620-1-9 pertaining to Accounts Receivable
	5	**PROCEDURE Item 4: New Item 4:** Any account with a balance of $50 or more requires three (3) collection efforts. **Change Reason:** Resulted from changes in the F&A rule and policy 0620-1-9 pertaining to Accounts Receivable
	6	**PROCEDURE Items 5-7:** Old item 4 becomes new item 5 and Items 5, 6 & 7 now become 6, 7 & 8. **Change Reason:** Resulted from changes in the F&A rule and policy 0620-1-9 pertaining to Accounts Receivable
	7	**PROCEDURE New Item 7: Change:** At each health department site, any write-off of an account of one thousand dollars ($1,000) or greater or accounts aggregating five thousand dollars ($5,000) or more must have the prior written approval of the Commissioner of Finance and Administration and the Comptroller of the Treasury. **To:** At each health department site, any write-off of an account of ~~one~~ five thousand dollars (~~$1,000~~$5,000) or greater or accounts aggregating ~~five~~ twenty-five thousand dollars (~~$5,000~~ $25,000) or more must have the prior written approval of the Commissioner of Finance and Administration and the Comptroller of the Treasury. **Change Reason:** Resulted from changes in the F&A rule and policy 0620-1-9 pertaining to Accounts Receivable
	8	**REFERENCE DOCUMENTS New Item 3:** Finance and Administration - Policy 23 **Change Reason:** Resulted from changes in the F&A rule and policy 0620-1-9 pertaining to Accounts Receivable
08/27/2001	1	**PROCEDURE, Item 6:** Change "6. Any write-off of an account of one thousand dollars ($1,000) or greater or accounts aggregating five thousand dollars ($5,000) or more must have the prior written approval of the Commissioner of Finance and Administration and the Comptroller of the Treasury." **TO:** "6. At each health department site, any ~~Any~~ write-off of an account of one thousand dollars ($1,000) or greater or accounts aggregating five thousand dollars ($5,000) or more must have the prior written approval of the Commissioner of Finance and Administration and the Comptroller of the Treasury." **CHANGE REASON:** For those write-offs that require prior approval, define each HD site as the organizational level to use as the

		basis for prior approval. This level would be used versus the region or State to reduce the number of prior approvals required.
	2	**PROCEDURE, Item 7:** Change "7. At least quarterly, those private pay services meeting these criteria will be written-off at the regional level. Quarterly, a summary report will be sent from the Regional Office to the Fiscal Services Section of the Bureau of Health Services (FSS) indicating the name, amount, and a notification of TennCare/Medicare eligibility." **TO:** "7. At least quarterly, those private pay services meeting these criteria will be written-off at the regional level. At least quarterly, ~~Quarterly,~~ a summary report will be sent from the Regional Office to the Fiscal Services Section of the Bureau of Health Services (FSS) indicating the name, amount, and a notification of TennCare/Medicare eligibility." **CHANGE REASON:** This change sets quarterly reporting as the minimum reporting period for write-offs.
03/13/2000	1	New Policy developed from old Policy 2.7--Accounts Receivable. The **PROCEDURE** section of this policy reflects the changes from the original policy. **PROCEDURE, 1st sentence:** Change "The following procedures must be used for maintenance of Accounts Receivable which arise from TennCare, Medicare, Medicare/TennCare (Dual Eligible), private insurance, CHAMPUS, and fees due from individual patients:" **TO:** "The following procedures must be used for maintenance of Accounts Receivable which arise from fees due from individual patients:"
	3	**PROCEDURE, items 1-3:** Old policy 2.7 item 5 "5. Collection of Fees from Individual Patients: If the balance of an account is below $75, at least one (1) collection effort is required. However, if the balance of the account is below $10, and an attempt to collect was made at the time the service was rendered, a statement does not need to be mailed to the patient. Any account with a balance of $75 or more requires three (3) documented collection efforts." **TO:** " 1. If the balance of an account is below $75, at least one (1) collection effort is required. 2. However, if the balance of the account is below $10, and an attempt to collect was made at the time the service was rendered, a statement does not need to be mailed to the patient. Any account with a balance of $75 or more requires three (3) documented collection efforts."

3/13/2000	4	**PROCEDURE, items 4-5:** Change old policy 2.7 from "All individual accounts will be aged at least quarterly using either of these PTBMIS reports: 1. TDH-HSA Bad Debt Write-Off Report or, 2. Patients with Write-Offs in Previous Report Period. Private pay services greater than 12 months old and for which the required collection efforts have been made will be reviewed for write-off based on the criteria that (a) there has been no private pay payment or, (b) there has been no transfer of charges from any payor to private pay for the entire patient's account during the preceding 12 months. This review will be done using PTBMIS to generate a list of services that meets either of these criteria." to " 4. All individual accounts will be aged at least quarterly using either of these PTBMIS reports (a) TDH-HSA Bad Debt Write-Off Report or, (b) Patients with Write-Offs in Previous Report Period. 5. Private pay services greater than 15 months old and for which the required collection efforts have been made will be reviewed for write-off based on the criteria that (a) there has been no private pay payment or, (b) there has been no patient encounter activity, except for the issuance of birth certificates, for the entire patient's account during the preceding 15 months. This review will be done using PTBMIS to generate a list of services that meets either of these criteria. "
	5	**PROCEDURE, items 6:** New item
	6	**PROCEDURE, items 7:** Change old policy 2.7 from "At least quarterly, those private pay services meeting these criteria will be written-off at the regional level. Quarterly, a report will be sent from the Regional Office to the Fiscal Services Section of the Bureau of Health Services (FSS) indicating the name, amount, and a notification of TennCare/Medicare eligibility." to "7. At least quarterly, those private pay services meeting these criteria will be written-off at the regional level. Quarterly, a summary report

		will be sent from the Regional Office to the Fiscal Services Section of the Bureau of Health Services (FSS) indicating the name, amount, and a notification of TennCare/Medicare eligibility."