Policy and Procedure Manual Administrative Departmental

Department: Patient Financial Services

Written: 02/05

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Revised: 07/06; 06/07; 08/12; 09/27/16

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<u>APPROVAL</u>: CFO: 09/27/16

Scope: X Medical Center



Medicare Bad Debt

I. PURPOSE / BACKGROUND

The purpose of this document is to ensure compliance with state and federal regulations when classifying Medicare accounts as bad debt.

Allowable Medicare bad debts are bad debts of the provider meeting the following criteria:

- The debt must be related to covered services and derived from deductibles and coinsurance amounts.
- Reasonable collection efforts were made, which includes documentation via copies of bills, follow-up letters, reports of telephone and personal contact, and at least 120 days duration from the original billing to the beneficiary.
- The debt is actually uncollected when claimed as worthless.
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

Incorrect reporting of reimbursable Medicare Bad Debt could be a violation of the False Claims Act and other laws.

II. POLICY

All Medicare account balances considered for bad debt will follow the established Patient Financial Services (PFS) departmental policy, *Self-Pay Collections*, including providing the debtor notification of his or her debt, and providing at least 120 days from the original billing to the beneficiary.

III. PROCEDURE

RESPONSIBLE PERSON(S)/DEPT.	PROCEDURE
PFS Collectors / Customer Service	 Self-Pay Collection (After Insurance Payment) In-House Collection Process 1. After insurance payment, validate if payment is correct and review Explanation of Benefits (EOB) to determine deductible and co-pay amounts. 2. If the financial class did not automatically change to self-pay, manually change the financial class to self-pay. 3. System will automatically generate patient statement/bill to be mailed to patient within 30 days of financial class change to self-pay.

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RESPONSIBLE
PERSON(S)/DEPT.

PROCEDURE

All Patient Balance Collections (Day 0–120)

- 1. Customer Service is responsible for soft collection activity up to 120 days. Patient notes must include all attempts to collect.
- 2. If unable to collect for 120 days, Customer Service to change accounts to Financial Class CBB which will generate a file for outsourcing to Vendor (CBB). Accounts now qualify as Bad Debt. This ends 120 day collection effort for Medicare.

Medicare Cross-Over Claims (Medi-Cal)

NOTE: The Cirius billing system is set-up to electronically cross-over all payers who conduct/accept EDI transactions. As additional payers are identified as being EDI-compliant, PFS Senior Manager will set-up payer identification (ID) through the billing system to allow such transactions to occur.

- After Medicare processes a claim and issues payment, Medicare will automatically cross-over (transmit via EDI) the claim to EDS (Medi-Cal), for secondary payment. (Staff will no longer write-off the Medi-Cal balance at the time of billing; only until the Medi-Cal payment is received and posted.)
- 2. When the Medi-Cal Electronic Remittance Advice (ERA) is received, review the ERA and determine the appropriate action if the claim was denied, or requires additional information for re-bill.
- 3. If claim is paid, remit will automatically post.
- 4. If claim is denied, charges will be written off to code 0024100-0 (Medi-Medi Billing).

Medicare Cross-Over Claims (Other Payers)

- 1. Medicare automatically transmits cross-over claims with other commercial payers who conduct/accept EDI transactions. (Such payers include Blue Cross, Blue Shield, Aetna, Cigna, PacifiCare, Tri-Care, Kaiser, etc.)
- 2. PFS receives daily a Noridian cross-over transmission report reflecting all claims sent to payers electronically for secondary payment consideration. This report shall be kept and reviewed periodically to reconcile claims pending secondary payment.

Bad Debt Pre-List Process (Government and Non-Government)

At day 118 (of the 120 day collection process), generate Bad Debt Pre-List Report. This list shows all accounts with no payment activity. Forward report to Senior Biller/Collector.

Revenue Cycle Systems Specialist / PFS Senior Biller / Collectors

- 1. Review pre-list for any account that should not go to Bad Debt. Diligently scrutinize this list to prevent claims from erroneous referral to Bad Debt Collection Agency.
- 2. Screen account balances against COH policy, *Charity Care*. If patient qualifies, adjust balance to appropriate charity care write-off code.
- 3. If accounts need to be held, assign appropriate Hold Code (which will hold claim for one week), or change Financial Class to Self-Pay, patient

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RESPONSIBLE	DD CCEDVIDE
PERSON(S)/DEPT.	PROCEDURE
	responsibility. 4. For accounts where no further action is required, claims will automatically transfer to Bad Debt. (Monitor Medicare Bad Debt.)
	Outside Collection Agency Process (Day 121-210)
	1. Vendor (CBB) is responsible for hard collection activity for additional 90 days and must provide monthly status updates, which includes a file of all Medicare and Non-Medicare Bad Debt accounts with Financial Class CBB. Patient notes must include all attempts to collect.
	2. Neither City of Hope National Medical Center ("COHNMC"), City of Hope Medical Foundation ("COHMF"), nor any vendors with which COHNMC or COHMF contracts for collection services routinely engage in extraordinary collection actions. As such, no Extraordinary Collection Actions (ECA) may be initiated without express written consent/approval by COHNMC and COHMF.
PFS Manager(s)	3. Monitor vendor's collection activity pursuant to agreement.
	DEPARTMENTAL PROCEDURES
PFS Personnel	 Accounts deemed as Medicare Bad Debt after failed attempts to collect over 120 days shall be handled as follows: a) Receive Bad Debt files from vendor (CBB). b) Upload files into PFM. c) Validate that all accounts within the CBB Medicare Bad Debt file contain documented collection activity, to include the Patient Friendly Bill.
	 Once validated, remove bad debt accounts from active A/R. Adjust (write-off) the account balances to the appropriate Medicare Bad Debt write-off code (0020390-1) based on the status assigned by CBB. All personnel performing Medicare Bad Debt write-offs will ensure all non-collectible account balances meet the following criteria: Relate to covered services and are derived from deductibles and coinsurance amounts; Remain uncollected after documented collection efforts; Be non-collectible at the time identified as Medicare Bad Debt; and Ensure that all Medicare patient balances are greater than 120 days from
Decision Support – Financial Analyst	 the original billing to the beneficiary. Forward Medicare Bad Debt files to Decision Support for Medicare Cost Reporting. Report monthly Bad Debt transfer totals to Vice President (VP) of Finance. Approval guidelines are as follows: a) Write-off up to \$10,000 – PFS Lead with Manager review b) Write-off \$10,001 up to \$100,000 – Manager review and signature c) Write-off over \$100,000 – Director and VP review and signature

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RESPONSIBLE PERSON(S)/DEPT.	PROCEDURE
PFS Lead(s) / PFS Manager(s)	 Compliance Monitoring Activity 1. Periodically verify adherence to the processes outlined in this policy. See PFS departmental policy, <i>Compliance Monitoring</i>. 2. Findings will be communicated to PFS management for possible education and training, and/or policy revision as warranted.

Owner: Senior Director, Patient Financial Services

Sponsor: Chief Financial Officer

Related Policies:

- 1. Charity Care
- 2. Compliance Monitoring (PFS Departmental)
- 3. Contractual Adjustments (PFS Departmental)
- 4. Self-Pay Collections (PFS Departmental)

Appendix One - Acronyms, Terms and Definitions Applicable to this Policy:

- 1. **Account Balance** The amount that remains outstanding on a patient's account. The account balance is a current balance and reflective of the financial actions performed on the account, including payments posted, contractual and non-contractual amounts. It is important to note that if the account reflects a \$0.00 balance, there may be an imbalance within the various financial buckets. The account should be reviewed and re-balanced appropriately within each bucket to ensure that the account is reflecting the appropriate balance.
- 2. **Administrative Adjustment** If a payer reimburses less than the expected amount, then a supervisor review and approval is required for this type of adjustment. At times, these may be referred to as "Non Contractual Adjustments." (Refer to the Contractual Adjustments Procedure for additional details.)
- 3. **Cash Posting** The process of posting a payment to a patient's accounts, as indicated and received from a patient or third party (i.e., insurance company, attorney, employer, etc.). The payer should be paying COH according to the contractual terms established by the Managed Care/Contracting Department per procedure or case. Upon contracting, COH will be reimbursed a certain rate per procedure or case, irrelevant of charges listed.
- 4. **COHMF** Refers to City of Hope Medical Foundation.
- 5. **COHNMC** Refers to City of Hope National Medical Center, also referred to as City of Hope ("COH") for purposes of this policy.
- 6. **Contractual Adjustments** This refers to the reduction of total charges based on a negotiated managed care contract rate between City of Hope (COH) and the payer for services rendered. The process of posting an amount of which the payer (as identified via the Cash Posting process), is not responsible for. The payer is not responsible for reimbursement of charges in excess of their contractual arrangement with COH.
- 7. **Explanation of Benefits (EOB)** A detailed summary of method of payment made by the payer, by patient account.
- 8. **Medical Center** Refers to all facilities covered by City of Hope National Medical Center's hospital license.
- 9. **Medicare Bad Debt** Refers to Medicare account balances deemed non-collectible after failed, repeated attempts to collect the account balance.
- 10. **Remittance Advice (RA)** A detailed list of payment methodology by a payer for multiple patient accounts.
- 11. **Total Charges** Charges for services provided to a patient for an entire length of stay (admit to discharge) or outpatient service. This includes late charges.

Attachment A: Transaction Code List

Attachment A: Transaction Code List

SVC CODE	DESCRIPTION	TRANS TYPE	MJR CODE	MJR CODE DESCRIPTION	CODE STATUS
212050	2ND OPINION W/O	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
212001	ADMINISTRATIVE ADJ.	ADJUSTMENT	21200	SUBSIDIZED CARE	ACTIVE
217000	AGENCY NON COLLECTIBLE	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
217018	AGENCY NON-COLLECT-M/C	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
217026	AGENCY NONCOLLECT-REVCARE	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
				MED ONCOLOGY-4TH FL	
209502	APC	ADJUSTMENT	20200	EAST	INACTIVE
207068	B/C C/A MEDSTAT	ADJUSTMENT	22500	CONTRACTUALS	ACTIVE
212506	B/C CONTRACTUAL MANUAL	ADJUSTMENT	22500	CONTRACTUALS	ACTIVE
225003	B/C CONTRACTUAL SYSTEM	ADJUSTMENT	22500	CONTRACTUALS	ACTIVE
225136	B/C DENIAL I/P DAYS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225391	B/C DENIAL-BLOOD	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225144	B/C DENIALCHEMO DRUGS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
231050	B/C DENIALLAB	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225151	B/C DENIALNO AUTH	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225169	B/C DENIALRADIOLOGY	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225508	B/C TEMP C/A	ADJUSTMENT	22500	CONTRACTUALS	ACTIVE
207076	B/S C/A MEDSTAT	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
217505	B/S CONTRACTUAL MANUAL	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
225201	B/S CONTRACTUAL SYSTEM	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225177	B/S DENIALCHEMO DRUGS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225185	B/S DENIALI/P DAYS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225193	B/S DENIALLAB	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225409	B/S DENIALNO AUTH	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225219	B/S DENIALRADIOLOGY	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
217604	B/S TEMP C/A	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
203100	BAB DEBT W/O	ADJUSTMENT	24400	BAD DEBT W/O	ACTIVE
203101	BAD DEBT AGENCY W/O	ADJUSTMENT	24500	BAD DEBT AGENCY W/O	ACTIVE
203117	BAD DEBT AGENCY W/O	ADJUSTMENT	21700	CONTRACTUALS	INACTIVE
203103	BAD DEBT OFFSET	ADJUSTMENT	24700	BAD DEBT OFFSET	ACTIVE
203133	BAD DEBT OFFSET	ADJUSTMENT	21700	CONTRACTUALS	INACTIVE
203102	BAD DEBT REATIVATE	ADJUSTMENT	24600	BAD DEBT REACTIVATE	ACTIVE
203125	BAD DEBT REATIVATE	ADJUSTMENT	21700	CONTRACTUALS	INACTIVE
203109	BAD DEBT W/O	ADJUSTMENT	21700	CONTRACTUALS	INACTIVE
231068	BAL PRORAT/CIRIUS	ADJUSTMENT	23100	CONTRACTUALS	ACTIVE
231035	BAL PRORAT/CUB	ADJUSTMENT	23100	CONTRACTUALS	ACTIVE
231019	BAL PRORAT/SYSTEM	ADJUSTMENT	23100	CONTRACTUALS	ACTIVE
231027	BAL PRORAT/VOF	ADJUSTMENT	23100	CONTRACTUALS	ACTIVE
213017	BAL PRTN,SM BAL<\$5.00V0F	ADJUSTMENT	23100	CONTRACTUALS	ACTIVE
231001	BALANCE PRORATION	ADJUSTMENT	23100	CONTRACTUALS	ACTIVE

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203000INS. BAD DEBT DEDUCTADJUSTMENT21700CONTRACTUALSACTIVE217901INSURANCE BAD DEBTADJUSTMENT21700CONTRACTUALSINACTIVE209528LEGAL CASE SETTLEMT W/OADJUSTMENT21000FREE CAREACTIVE	242024	INGNT W/O,PT DEC'D/NO EST	ADJUSTMENT	21000	FREE CARE	ACTIVE
217901INSURANCE BAD DEBTADJUSTMENT21700CONTRACTUALSINACTIVE209528LEGAL CASE SETTLEMT W/OADJUSTMENT21000FREE CAREACTIVE	203018	INS. BAD DEBT CO-PYMT	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
209528 LEGAL CASE SETTLEMT W/O ADJUSTMENT 21000 FREE CARE ACTIVE	203000	INS. BAD DEBT DEDUCT	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
- 	217901	INSURANCE BAD DEBT	ADJUSTMENT	21700	CONTRACTUALS	INACTIVE
206003 M/C CONT SYST ADJUSTMENT 20600 BMT-6TH FL EAST&WEST ACTIVE	209528	LEGAL CASE SETTLEMT W/O	ADJUSTMENT	21000	FREE CARE	ACTIVE
	206003	M/C CONT SYST	ADJUSTMENT	20600	BMT-6TH FL EAST&WEST	ACTIVE

212027	M/C NON COV(MEDASYS)	ADJUSTMENT	20800	M/C NON COV (MEDASYS)	INACTIVE
212027	in, energe con (inizariore)	7.050011112111	20000	MED ONCOLOGY-4TH FL	110,101112
202010	M/CARE CONT,MANUAL	ADJUSTMENT	20200	EAST	ACTIVE
				MED ONCOLOGY-4TH FL	
202002	M/CARE CONT,SYST	ADJUSTMENT	20200	EAST	ACTIVE
225334	M/CARE DENIAL-CHMO DRUGS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225359	M/CARE DENIAL-RADIOLOGY	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
205559	M/CARE N/C CIRIUS	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
225331	MCAL ADMIT STAT CHNGE WO	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
205583	MCARE DENIAL, HOME HEALTH	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
203026	MCARE DNLS/STATUTORY EXCL	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
205062	MCR ADR DENIAL/NO DOC/NEC	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225325	MCRE ADMIT STAT CHANGE WO	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
205054	MCRE ADR DENIALS/MD SIG	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
205104	MCRE ADR DENIALS/RX WASTE	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
212068	MED GRP ADJMT, AGING	ADJUSTMENT	21200	SUBSIDIZED CARE	ACTIVE
207043	MEDI-CAL C/A MEDSTAT	ADJUSTMENT	20600	BMT-6TH FL EAST&WEST	ACTIVE
206011	MEDI-CAL CONT (MDX)	ADJUSTMENT	20600	BMT-6TH FL EAST&WEST	ACTIVE
212019	MEDI-CAL CONT.(MEDASYS)	ADJUSTMENT	20600	BMT-6TH FL EAST&WEST	INACTIVE
208504	MEDI-CAL CONTR MAN	ADJUSTMENT	20600	BMT-6TH FL EAST&WEST	ACTIVE
208512	MEDI-CAL COST SETTLMT ADJ	ADJUSTMENT	20600	BMT-6TH FL EAST&WEST	ACTIVE
212043	MEDI-CAL DENIAL-CHMO DRUG	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225086	MEDI-CAL DENIAL-I/P DAYS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225268	MEDI-CAL DENIALLAB	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225292	MEDI-CAL DENIALNO AUTH(ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225276	MEDI-CAL DENIALPHARMACY	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225284	MEDI-CAL DENIAL-RADIOLOGY	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225300	MEDI-CAL NON COV PHOTOPHR	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
207001	MEDI-CAL NON COVD	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
207019	MEDI-CAL NON COVD(MDX)	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
225078	MEDI-CAL PAST BILLING LIM	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
235408	MEDI-CAL RESTRICT MANUAL	ADJUSTMENT	22200	FREE CARE	ACTIVE
235416	MEDI-CAL RESTRICT SYST	ADJUSTMENT	22300	FREE CARE	ACTIVE
225318	MEDI-CAL, BLOOD PROD-COH	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
207027	MEDI-CAL, LMRP	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
ļ				MED ONCOLOGY-4TH FL	
203901	MEDICARE BAD DEBT	ADJUSTMENT	20200	EAST	ACTIVE
207035	MEDICARE C/A MEDSTAT	ADJUSTMENT	20200	MED ONCOLOGY-4TH FL EAST	ACTIVE
205010	MEDICARE C/A MEDSTAT	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
205575	MEDICARE DENIAL QIO	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
205005	MEDICARE DENIAL/BENEFIT	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
207126	MEDICARE DENIAL/BENEFIT	ADJUSTMENT	20700	DENIALS OTHER DENIALS OTHER	ACTIVE
Z0/1Z0	MILDICANT DEMIAT-ESA	עראַסאַן ואובואון א	20/00	DEINIALS OTHER	ACTIVE

225342	MEDICARE DENIALLAB	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225326	MEDICARE DENIALSNF	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
223320	WESTORINE SERVICE SIVI	ADJOSTIVILIVI	20700	MED ONCOLOGY-4TH FL	ACTIVE
238006	MEDICARE LATE CHARGE	ADJUSTMENT	20200	EAST	ACTIVE
225920	MEDICARE LMRP	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225938	MEDICARE LMRP/CIRIUS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
205050	MEDICARE MUE/MUA DNL	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
205567	MEDICARE NMDP	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225128	MEDICARE -PHOTOPHERESIS	ADJUSTMENT	20900	PEDS-3RD FLOOR WEST	ACTIVE
205073	MEDICARE RAC DENIAL	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
241000	MEDI-MEDI BILLING	ADJUSTMENT	22400	FREE CARE	ACTIVE
212076	MEDSTAT VARIANCE	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
207084	MISC C/A MEDSTAT	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
242008	MISC CONTRACTUAL MANUAL	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
218008	MISC CONTRACTUAL SYSTEM	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
225052	MISC DENIALI/P DAYS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225037	MISC DENIALNO AUTH	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
207506	MISC TEMP C/A	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
225375	MISC, DENIALCHEMO DRUGS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225383	MISC, DENIALLAB	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225367	MISC, DENIALRADIOLGY	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
231993	MUTUAL EXCLS/CMS NO-MOD	ADJUSTMENT	20400	EAST HOSPITAL-UNIT B	ACTIVE
230003	NO DIAGNOSIS < \$300.00	ADJUSTMENT	21000	FREE CARE	INACTIVE
218115	NO M.D. DOCUMTATION ADJMT	ADJUSTMENT	21200	SUBSIDIZED CARE	ACTIVE
225904	OTHER BAD DEBT	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
212035	PAST BILL LT,M/CAL MDASYS	ADJUSTMENT	20600	BMT-6TH FL EAST&WEST	INACTIVE
				MED ONCOLOGY-4TH FL	
225102	PAST BILLG LIMITS,M/CARE	ADJUSTMENT	20200	EAST	ACTIVE
225011	PAST BILLING LIMITS, B/C	ADJUSTMENT	22500	CONTRACTUALS	ACTIVE
225045	PAST BILLING LIMITS, MISC	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
212209	PATIENT AGREEMENT	ADJUSTMENT	21200	SUBSIDIZED CARE	ACTIVE
212084	PAYMT VARIANCE,KAISER	ADJUSTMENT	21200	SUBSIDIZED CARE	ACTIVE
231043	POST COMPLIANCE REV W/O	ADJUSTMENT	21200	SUBSIDIZED CARE	ACTIVE
209510	PROFESS COURTESY W/O	ADJUSTMENT	21000	FREE CARE	ACTIVE
225946	PROFESSIONAL COURTESY W/O	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
232504	REFUND LIABILITY ACCT.	ADJUSTMENT	23200	NO LONGER USED	INACTIVE
232009	REFUND REGULAR ACCOUNT	ADJUSTMENT	23200	NO LONGER USED	INACTIVE
232108	REFUND REGULAR ACCT	ADJUSTMENT	10100	REFUND	ACTIVE
244525	SM BAL W/O<\$100/CCS	ADJUSTMENT	20600	BMT-6TH FL EAST&WEST	ACTIVE
244517	SM BAL W/O<\$100/M-CAL	ADJUSTMENT	20600	BMT-6TH FL EAST&WEST	ACTIVE
213009	SMALL BAL < \$25.00 MANUAL	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
213025	SMALL BAL. SYSTEM < 25.00	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
225912	SPIRAT GRANT W/O	ADJUSTMENT	21700	CONTRACTUALS	INACTIVE

201210	SURVIVORSHIP CLINIC W/O	ADJUSTMENT	21200	SUBSIDIZED CARE	ACTIVE
208041	TOMOTHERAPY DENIAL - B/SD	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
208025	TOMOTHERAPY DENIAL - BC	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
208058	TOMOTHERAPY DENIAL - CCS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
208033	TOMOTHERAPY DENIAL - CMS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
208066	TOMOTHERAPY DENIAL - M/CL	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
208074	TOMOTHERAPY DENIAL - MIS	ADJUSTMENT	20700	DENIALS OTHER	ACTIVE
225953	TRIAGE, WORK-COMP W/O	ADJUSTMENT	21700	CONTRACTUALS	ACTIVE
201202	UNFUNDED RESEARCH W/O	ADJUSTMENT	21200	SUBSIDIZED CARE	ACTIVE
233007	UNIDENTIFIED CASH	ADJUSTMENT	23300	NO LONGER USED	INACTIVE