Explanation of Amounts Generally Billed

At CAMC the AGB is determined through the “Look-back method” which is calculated as follows:

1. Reviewing all past claims allowed by Medicare fee-for-service together with all private health insurers paying claims to the hospital in a prior 12-month period. This amount can include co-insurance; copayments and deductibles. Current AGB is 44.30%.
2. The AGB for emergency or medically necessary care provided to a financial assistance eligible individual is determined by multiplying gross charges for that care by one or more percentages of gross charges (called "AGB percentages").
    a. The percentages are calculated at least annually by dividing the sum of certain claims allowed by health insurers during the prior 12-month period by the sum of the associated gross charges for those claims.
    b. Multiple AGB percentages may be calculated for separate categories of care (for example, in-patient verses out-patient care; or care provided by different departments) or for separate items or services.
3. The percentages are applied by the 120th day after the end of the 12-month period the hospital facility used in calculating the AGB percentage(s).

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