

POLICY AND GUIDELINE

TOMAH HEALTH

Tomah, Wisconsin 54660

EFFECTIVE DATE: 04/20/2021

DIVISION: Business Management

P&G #: 200-ACC-003

ORIGINATION DATE: 2/95

TITLE: Management of Accounts Receivable

PAGES: 1 of 6

Author DATE: _____

Approved By: _____ DATE: _____
Administrative Team Leader

Board of Directors DATE: _____

01. INVOLVES

Patient Financial Services, Patient Access Services, Prior-Auth & Scheduling Services, HIS, & Patient Financial Counseling

02. PURPOSE

To provide general guidelines for the collection of accounts receivable.

03. POLICY

The financial stability of Tomah Health (TH) relies upon the accuracy of our billing and the timeliness of the collection of patient accounts receivable. Guidelines for collection are approved by the Board of Directors and are intended to ensure that all billing and collection activities are conducted in a patient-friendly manner.

04. GUIDELINES

- A. Hospital staff will maintain a commitment to collect, manage and report (billing) data in an unbiased, honest and ethical manner.
- B. Hospital staff will maintain good relations with our patients, and the community we serve by performing all aspects of the billing process in a professional, courteous and timely manner.
- C. All bills will be processed in accordance with Medicare, Medicaid, Internal Revenue Service, and other third party payer regulations to the best of our ability (including any discounts offered automatically to uninsured patients or patients who would qualify for financial assistance).
- D. Hospital staff agrees to refer any coding discrepancies directly to Health Information Services (HIS) and acknowledge that it is the responsibility of HIS to document any coding changes that arise as a result of the billing process.

- E. Hospital staff is committed to providing the support needed to effectively classify our patients, and will not misrepresent their classification in order to obtain a higher level of reimbursement or to reduce the patient's liability. Any adjustments to account balances will follow Administrative and/or Department guidelines.
- F. All records and information, including knowledge of a debt, will be held in strictest confidence. Debts and specifics regarding a patient bill will only be discussed with the patient or a representative the patient has approved, the guarantor, a legal party, third party payer, or internal staff (on an as-needed basis and per all applicable HIPAA guidelines).
- G. Any billing errors that are discovered will be corrected to comply with applicable regulations. Late charge(s) received greater than 60 days from service date will not be posted, however all late charge credits will be keyed regardless.
- H. All members of the Patient Financial Services Department will remain current on the various billing regulations and collection techniques.
- I. Refunds owed to Patient/Guarantor are to be completed within 45 days of credit balance.

Patient Access Services and Prior-Auth & Scheduling staff responsibility

- A. Effective management of Accounts Receivable begins with the Patient Access Services and Prior-Auth & Scheduling staff. The Patient Access Services Staff will obtain accurate and complete demographic and financial information from patients in an efficient and courteous manner, thus allowing timely billing and payment from third party payers. It is the responsibility of staff to initially identify and refer patients who may be in need of financial counseling due to inadequate insurance coverage to the Patient Financial Counselor. EMTALA guidelines will be followed on all patients presenting for non-scheduled services (Emergency Services, Urgent Care Services and Warrens Clinic).
- B. Patient Access Services and Prior-Auth & Scheduling staff are required to verify all insurance plans using eligibility tools provided. If tools are not available, it is the expectation that they would follow up with patient or insurance carrier until information has been confirmed. This includes working accounts from a queue and/or failed bill.
- C. Although it is ultimately the patient's responsibility to know their plan's precertification requirements, reasonable efforts will be made by Patient Access Services and Prior-Auth & Scheduling staff, to identify situations where precertification/authorization is required by the third party payer and to assist the patient in meeting that requirement prior to scheduling or providing service. This process will require cooperation and assistance from the ordering physician and departments.
- D. Patient Access Services Staff and Prior-Auth & Scheduling staff will attempt to identify individuals that are enrolled in a government-sponsored insurance plan (e.g. Medicare, Medicaid, Tricare/Champus) and ensure they or their designee are notified of all applicable rules and regulations regarding their episode of care, including potential deductible and coinsurance liabilities, precertification requirements, and required paperwork (including provider-based notifications and MSP notification).

Patient Responsibility

- A. The patient, unless a minor or legally incompetent, is generally responsible for payment of services rendered. Any individual signing the financial responsibility form agrees to be held liable for payment of the related services.
- B. TH will supply all documents needed as requested by the patient or his/her representative in pursuing litigation against another party such as an automobile accident. However, TH will seek to avoid active involvement in disputes arising from these claims and payment for services rendered will be expected in a timely manner as outlined in this policy.

Billing to Third Party Payers:

- A. If provided with current, accurate health insurance information, a claim will be filed to all primary and secondary insurance companies on behalf of the patient. If accurate information was not provided, at the time of service, and patient updates insurance after timely filing provisions of their plan, the account will be classified as Self Pay and the patient will be billed directly.
- B. Every attempt will be made to bill all accounts within 4 days of discharge. Resolution of billing errors via the Claim Edit Workqueue will be done on a daily basis. To ensure compliance with various billing regulations, claims will be resolved in an appropriate manner. Claims cannot be “forced” final billed without the permission of the Director, or the Director’s designee.
- C. Third party payers will be allowed a reasonable amount of time to process a claim. If the initial claim is not processed within 45 days of submission, follow up will be made by the biller assigned to the account. The manner of follow up, prior to resubmission of a claim, will include internet inquiry, phone contact with the insurer, and/or fax inquiries to the payer.

If it is determined that the reason a claim has not been processed is failure by the patient to respond to requested information from the insurer, reasonable efforts will be made to contact the patient and encourage them to respond to their insurer. The account will be noted and the balance will be moved to the next responsible Party, self-pay. The accounts will then follow the same path as other accounts in self-pay and could result in collection efforts.

- D. Patients will be balance billed for any deductibles, coinsurance, or non-covered charges (including Self-Administered Drugs-SAD’s).
- E. Notations regarding any billing or follow up will be documented in the notes section of the patient’s account. All calls received or made are to be documented in the notes, even if nothing needed to be completed.

Billing for Accounts Considered Self Pay

A. Once an account has moved to self-pay status they will received the first statement with an itemized list of services provided. After first statement charges will be summarized by revenue code description and date of service. All self-pay status account will be referred to our Extended Business Office and follow up will begin in 45 days, from statement date. Monthly guarantor statements will continue to be sent by TH.

B. Time Pay Management Accounts

If an employee contacts the Patient Financial Service office to establish acceptable payment arrangements:

These employee's will still receive a statement. Patient Financial Service Payment Posters will set up the payment arrangement and then notify the Patient Financial Services Counselors. They will then apply a billing indicator to stop our EBO from making any phone calls to the employees.

All employee Time Pay accounts are monitored by the Patient Financial Services Posting staff. All other time pay accounts are managed by the Extended Business Office vendor. Calls only go out on Time Pay accounts if payment is not made within 45 days of statement date.

C. Both TH and the Extended Business Office will follow the same collection guidelines:

1. The attached payment plan Matrix provides guidelines to staff when establishing payment plan with patients. Extended business office may negotiate these payment plans on behalf of TH, but will need approval from TH if the need to deviate from matrix guidelines. Patient Financial Services staff or a member of Administration can use their discretion to negotiate acceptable payment arrangements that may fall outside the guidelines suggested by the matrix.
2. Payment arrangements are based upon the date the account became a self-pay balance and not the date the patient makes payment arrangements.
3. All unpaid balances on account for the guarantor will be considered in determining the appropriate payment. If new account balances are incurred, the monthly payment may need to be adjusted to accommodate the higher balance.
4. The PFS and Extended Business office staff are to make reasonable attempts to screen all patients/guarantors for financial assistance prior to referring account for Bad debt collections. Account follow-up notes will document financial screening
5. Before an account can be turned over to collection, the guarantor must receive a minimum of 3 statements (Final Summary and/or Guar Statement), minimum of one phone attempt, and a Final notice.
6. Employees of TH will not be exempt from the payment guidelines.

7. An account is considered Self-Pay if one of the following situations occurs:

- a) Patient indicates no third party coverage. (Qualifies for uninsured discount).
- b) Patient failed to provide TH with correct third party billing information.
- c) Patient failed to respond to a request for information from the insurer, and the insurer rejects the claim.
- d) Insurer has processed the claim and coinsurance/deductible/non-covered balances are now the patient's responsibility.

Extended Business Office

- A. TH utilizes the service of an outside agency to assist in collecting on accounts classified as self pay (the Extended Business Office, or EBO). The EBO follows all policies established by TH, and has secure access to the TH business office system. EBO users are added and removed as authorized by the Patient Financial Service Director and/or EBO designated contact person.
- B. All payments are made by the patient directly to TH. Written communication is made on TH letterhead and phone number on statements goes directly to the EBO whom answers as TH. Accounts placed at the EBO are not in a collection or bad debt status, but remain on the hospital's general ledger until paid or referred for collection activity. The EBO is also responsible for screening for charity care and creating and monitoring time pay arrangements. EBO drives when the final notice is sent and when accounts are referred to collections.

Delinquent Accounts

- A. An account may be classified delinquent if no payment has been received, or payment arrangements have been agreed to. The EBO will drive the process for delinquent accounts. The EBO will receive the account immediately upon final bill and wait, 45 days from first statement to attempt collection for a minimum of 180 and not greater than 230 days; if unsuccessful they will then close the account and recommend to be turned over to our collection agency. Accounts will not be referred to our collection agency prior to 180 days from first statement date, a minimum of three statements and a final notice letter.

Account Settlement Offers

TH generally does not extend discounts to third party payers with whom no formal contractual arrangement exists, or to individuals that have not pursued a discount via the hospital's community care program. Offers by third party payers and individuals to settle accounts with a lump sum payment in exchange for a discount (generally considered a prompt pay discount) will be considered on a case-by-case basis and must be approved by either the Director of Patient Financial Services or the Chief Financial Officer. Factors to be considered in determining whether or not to accept a particular settlement offer will include a review of insurance coverage, collection history, offering party (e.g. individual, insurance company, third-party negotiator, attorney), balance type (i.e. balance in full or balance after insurance payment), and probability of collection absent a settlement agreement. Individual settlement agreements will comply with all applicable State and Federal rules and regulations regarding allowable collection activities.

05. FORMS

None (Policy also found on the TH Website)

06. REFERENCE

Short-Term Payment Matrix

Minimum monthly payment is *\$25.00

TOMAH HEALTH Short-Term Payment Policy

<u>Account Balance Amount</u>	<u>Maximum Duration</u>
\$.01- \$499.99	6 months
\$500.00-\$2,999.99	12 months
\$3,000>	18 months

Note: The monthly payment time duration noted above are intended to provide guidance for Patient Financial Services staff in determining appropriate payment arrangements. Patient Financial Services and Early out vendor staff can offer up to two additional months to the Maximum duration without Director approval. To deviate further requires Financial Assistance screening and Director approval.