POLICY AND GUIDELINE

TOMAH HEALTH

Tomah, Wisconsin 54660

EFFECTIVE DATE: 02/17/2026
DIVISION: Business Management
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TITLE: Management of Accounts Receivable
PAGES: 1 of 6

_____ DATE: _____
Author

Approved By: _____ DATE: _____
Administrative Team Leader

_____ DATE: _____
Compliance Committee

_____ DATE: _____
Board of Directors

INVOLVES

The "Revenue Cycle" consists of the following departments: Patient Financial Services, Patient Access Services, Prior-Authorization, Scheduling, HIS, & IS.

PURPOSE

To provide general guidelines for the collection of accounts receivable.

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.

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 agree 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 charges will always be keyed regardless of credit or debit. Credits will be rebilled to the corresponding Payer. Debits will be reviewed based amount and payer.

H. All members of the "Revenue Cycle" will remain current on the various billing regulations.

<u>Preregistration staff responsibility</u>

A. Effective management of Accounts Receivable begins with the preregistration services. Preregistration staff are considered any Tomah Health staff that actively schedule, register, verify patient demographics, and coverage. This is obtaining accurate and complete patient demographics, insurance verification, and financial information from patients in an efficient and courteous manner. This allows for timely billing and payment from third party payers and patients
    a. At the time of scheduling, insurance needs to be verified and attached to the appointment. Due to No Surprise Billing Act, any uninsured or out of network patients will receive a Good Faith Estimate if scheduled three business days prior to visit. These accounts are set to automatically route to a Work queue within our electronic medical record.
    b. Any unscheduled visits or visits that are scheduled and seen in under the three day are not required to have a Good Faith Estimate.
    c. Admitting Staff notify Patient Financial Services Counselor of any inpatient admits. Patient Financial Counselor's will then attempt to reach out to the patients room to see if they have any immediate questions, financial aid application will then be mailed to patients listed address. EMTALA guidelines will be followed on all patients presenting for non-scheduled services (Emergency Services, Urgent Care Services).

B. Preregistration staff are required to verify all insurance plans using eligibility tools provided before scheduling patients for services. If tools are not available, it is the expectation that they will 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 preregistration staff, to identify situations where precertification/authorization is required by the third party payer. To manage accounts receivable, patients are scheduled 14 days out from appointment request to provide enough time for Prior Authorizations to be received. This process will require cooperation and assistance from the ordering physician and departments.

D. Preregistration 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 billed to the payer but it will be the patient's responsibility to help appeal the possible denial.

B. Every attempt will be made to bill all accounts within 4 days of discharge. Resolution of registration, coding, charging, and billing errors via the Claim Edit Work queue 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 corresponding work queues depending on account specifics. Follow up will begin 45 days from the statement date, monthly guarantor statements will continue to be sent by TH. The patients account will flow through normal collection work queues based on the criteria denied within the electronic health system.

B. Payment Plans

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. All employee approved payroll deduct accounts are monitored by the Patient Financial Services Posting staff. Payment posters will notify the Pay Roll Specialist for them to enter payment information into ADP.

C. TH will follow the collection guidelines:

1. Payment arrangements are based upon the date the account became a self-pay balance and not the date the patient makes payment arrangements.
2. 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.
3. PFS is 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
4. Before an account can be turned over to collection, the guarantor must receive a minimum of 5 statements (Final Summary and/or Guar Statement), minimum of one phone attempt, and a Final notice.
5. Employees of TH will not be exempt from the payment guidelines.

6. 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.

Delinquent Accounts

A. An account may be classified delinquent if no payment has been received, or payment arrangements have been agreed to. PFS 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.

Overpayments

A. Funds that are received or retained from insurance, patient/guarantor, company to which Tomah Health is not entitled. An overpayment may be the result of, but is not limited to, any of the following:
   a. Non-adherence to federal healthcare program requirements;
   b. Errors by hospital personnel;
   c. Payment processing errors by the payor; or
   d. Erroneous or incomplete information provided to hospital by the patient or responsible party, etc.

B. To comply with the False Claims Act "FCA" overpayments are to be resolved within 60 days of the credit being identified. Patient Financial Services is responsible for monitoring potential overpayments, including various claims reconciliation processes such as the review of credit balances and other reports. Patient Financial Services is responsible for the return of overpayments through standard claims adjustment or reversal processes. Isolated clerical errors, unintended claim specific coding, charging or billing errors, or any non-repetitive errors, etc., resulting in an overpayment will be managed in the normal course of business and refunded within 60 days of being identified.

C. Accounts that are in a credit balance automatically route to Work queues with the EMR. Patients accounts are dispersed into workqueue based on where the credit stands, all Patient Financial Services staff are responsible for reviewing credits with 7 days of the account entering the work queue.
D. Patient Financial Director will monitor credits on a monthly basis for those approaching the 60 days with outstanding credit. Report is found within EPIC; TMH HB Dashboard Bucket Credit Drill-down
E. An annual review is conducted of the Hospital's fiscal year end outstanding check list, and any items that qualify as unclaimed property per Wisconsin State Statutes Chapter 177 are submitted to the State of Wisconsin via the Department of Revenue online portal along with the applicable payment amount.

FORMS

None (Policy also found on the TH Website)

COMPETENCY/REFERENCE DOCUMENTS (RD)

None

LIPPINCOTT PROCEDURES

REFERENCE

Short-Term Payment Matrix

Minimum monthly payment is *$25.00

Guarantor Payment History Score	Minimum Balance	Maximum Balance	Max # of Payments	Min Monthly Amount	Proposed # of Payments
5	50.00	3,500.00	36	25.00	7
5	3,500.01		36	25.00	36
4	50.00	7,000.00	36	25.00	14
4	7,000.01		36	25.00	36
3	50.00	9,000.00	36	25.00	21
3	9,000.01		36	25.00	36
2	50.00	10,500.00	36	25.00	28
2	10,500.01		36	25.00	36
1	50.00		36	25.00	36
BLANK (No Pmt History)	50.00		36	25.00	36

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.