Central Texas
Rehabilitation Hospital
A Seton Healthcare Family Partner
with Kindred Healthcare

Policy Title:	Accounts Receivable - Meditech			
Section /Policy:	PTA 10.24		Effective Date:	9/11/2019
			Date Reviewed:	9/10/2019
			Revision Date:	

TITLE: Accounts Receivable

POLICY

Patient account balances shall be monitored to ensure proper valuation and timely collection. Adequate collection efforts shall be performed and documented in Meditech.

PROCEDURES

This policy applies to all patients accounts.

I. **Change in Insurance Benefits**

If new benefits are discovered during a patient's stay or benefits are found to be in error, the information should be noted in the collection notes and the guarantor updated in the billing system.

II. **Monitor Patient Account Balances**

A. To ensure accurate and timely reconciliation of accounts the following collection schedule will be implemented:

1) Initial follow up call will be made 14 days after claim submission.

2) Subsequent follow up call(s) will be made every 14 days.

III. **Review of Payor Classification**

The CBO/designee shall determine if payor balances and revenues should be restated via changing the insurance contract data set up. A/R should not be transferred between payors due to changes in payor classification using the Edit Insurance Balance routine.
The Edit Insurance Balance routine is only applicable to transfers of coinsurance and deductibles between payors and self – pay.

The CFO/Controller shall review the current A/R Aging report during the Meditech close process, and the timeframe between Meditech close and SAP close, looking for payor classification or other errors to ensure the propriety of patient balances. A final version of the A/R Aging shall be printed, reviewed, signed, and dated by the Controller after Meditech close and prior to SAP close and retained for at least 1 year.

IV. Documentation of Collection Efforts

1) The Director of Patient Accounting shall assign collectors to patient accounts. The frequency of collection efforts shall be, at a minimum, as follows: Initial follow up call will be made 14 days after claim submission.
2) Subsequent follow up call(s) will be made every 14 days.

The Collector shall document all collection efforts (telephone calls or letters to and from insurance company, patient, patient's family, etc.) in the Notes section of the patient's account in Meditech.

Pathway: BAR> Process Account > Account Name or Number > Collections > Enter/Edit Comments > Create

The following items, at a minimum, shall be documented by the Collector in the system notes immediately after completing a collection procedure:

- Full name of person, title and phone number with whom Collector has spoken.
- Payment status, including specific details of any missing documentation needed in order to move the claim forward, as well as any escalation to supervisor.
- Dollar amount of expected payment.
- Expected payment date, if available.
- Inability or refusal to pay (communication shall be provided to CBO/designee).

Hardcopy of all written correspondence to/from the payer shall be included in the patient's VPFF file.

V. Use of Outside Collection Agencies or Attorney

The CBO shall identify patient accounts that should be considered for placement with an outside collection agency.

Claims cannot be placed with an agency until the CBO has exhausted their collection efforts. At a minimum, this includes 3 letters/statements and 1 phone call to the patient to collect the outstanding balance.

The CBO will email this list of possible claims to the hospital Controller for approval to place with the collection agency. The Controller will respond to the email with approval of any claims to place with the outside agency after he/she has confirmed that the CBO has exhausted their collection efforts.

If the agency is unsuccessful in collection efforts after 120 from placement, the account can then be pulled back from the agency for possible bad debt write-off.

Utilization of Corporate Legal and/or Outside Attorney

Litigation of patient accounts should be initiated after all reasonable efforts to collect have been exhausted. Outside counsel shall seek final approval from Kindred Legal Counsel after a review is performed by the Division Vice President of Finance.
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In cases where legal action is required, the CBO/designee shall prepare a Legal Request. This form, along with supporting documentation, shall be approved by the DVP Finance/designee for approval.

VI. Patient Account Credit Balances

The CBO/designee is responsible for reviewing and resolving credit balances in a timely manner. All credit balances shall have documentation in the notes as to the reason for the credit balance. The Controller shall review the month-end Meditech credit balance report both during the Meditech close process, and the timeframe between Meditech close and SAP close. A final version of the Meditech credit balance report shall be printed, reviewed, signed, and dated by the Controller after Meditech close and prior to SAP close and retained for at least 1 year.

Patient refund requests shall be documented on a Patient Refund Form and submitted to the CBO and CFO/Controller for approval prior to posting in the Meditech system. Refund request authorization levels are as follows:

CBO Director/Manager	$0 to $10,000
IRF Director of Accounting	$10,001 to 50,000
DVPF	$50,001+

Email/electronic signature shall also suffice for approval on adjustment/refunds, etc. All back up and support for the refund shall be maintained along with a copy of email/electronic signature approval. All supporting documentation shall be scanned into the SAP A/P System.

Once a patient refund is posted in the Meditech System, it automatically interfaces to SAP as a parked document for posting by the Controller. The payee name and address must be correct in the Meditech System prior to posting the refund.

The CBO/designee is responsible for completing the Medicare Credit Balance Report within 30 days after the close of each calendar quarter. The IRF Director of Accounting or the Controller shall approve this report prior to submittal. Failure to submit this report may result in suspension of payments by Medicare.

VII. Adjustments to Patient Accounts

Patient account balances shall be stated at their net realizable value.

The Meditech System automatically posts contractual allowances based on contract terms established on patient accounts.

The CBO/designee shall make payer changes and payment term changes within Meditech, if required, and reasons for payor/payment changes shall be documented in the Meditech collection notes.

Should an account require a manual adjustment (i.e. complicated commercial contract, self-pay adjustment, bad debt write offs, etc.), the adjustment shall be documented on an Adjustment Log Form. All back up and support shall be maintained along with a copy of the email/electronic signature approval for one year.

Manual adjustment approval requirements are as follows (email/electronic signature shall also suffice for approval):

- CBO Director $1-$25,000
- IRF Accounting Director $25,001-$50,000
- DVPF $50,000 +

NOTE: Manual adjustments are not affected (i.e. not reversed) when bills are reversed, therefore, these adjustments should be reviewed and revised, if necessary, to accurately state net patient revenue.

The Controller shall review the Meditech Manual Adjustment Journal both during the Meditech close process, and the timeframe between Meditech close and SAP close. A final version of the Meditech Manual Adjustment Journal shall be printed, reviewed, signed, and dated by the Controller after Meditech close and prior to SAP close and retained for at least 1 year.

Meditech Pathway: BAR > Batches > Adjustments Journal (Note: In order to capture both positive and negative adjustments on the report, you must input a negative dollar amount in the "From Adj Amount" field, i.e. $-1,000,000 and a positive amount in the "Thru Adj Amount" field, i.e. $1,000,000).

VIII. Commercial and Self-Pay Discounts

Commercial and self-pay discounts shall be approved by the Controller. Discounts may be warranted to ensure prompt payment or to secure payment without pursuing collection actions.

If an insurance company requests a discount from policy benefits after a patient is admitted, the Controller shall be notified and must approve the discount.

The Controller shall obtain approval from the CEO and DVPF prior to negotiating discounts in excess of $50,000 per account.

In accordance with Medicare regulations, inpatient Medicare co-insurance and deductibles may not be waived.

IX. Patients who qualify for financial assistance

Patients who qualify for financial assistance shall be identified upon admission or prior to exhaustion of other payer benefits. See **Summary of Financial Assistance Policy** for detail on qualifications and details on charity write-offs. When a Medicare patient exhausts benefits and has no supplemental insurance or other resources, they may qualify for charity write-offs.

The CBO/designee shall determine the indigence of a patient, as follows:

- Patient is eligible for Medicaid but benefits have exhausted.

- Patient provides evidence of low income via bank statements, social security checks, etc. (refer to State guidelines for Charity healthcare).

After a patient is determined to be eligible for a charity write-off, the related claim balances shall be moved to Charity in the Meditech system, and the Charity adjustment code shall be used to write-off these balances.

X. Extended Payment Arrangements

The CFO/Controller shall determine whether extended payment arrangements will be granted to patients, and DVP Finance approval is required.

The CFO/Controller shall determine whether a signed Promissory Note should be executed based upon the dollar amount of the account and the length of time for final payment. The Corporate Legal Department shall be contacted regarding potential promissory notes.

The Collectors shall review all accounts under extended payment arrangements on a monthly basis to ensure that payments are made in accordance with the agreement. If payment is not made, the Collector shall notify the CBO Director for appropriate action.

NOTE: Utilize the following routine to set-up extended payment arrangements:
BAR => Process Account => Collections => Contract/Agency → Edit Contract

XI. Bad Debts

Accounts shall not be written off to bad debt until all appropriate collection efforts have been exhausted by the CBO. Hospital Controller/CBO/designee shall review all patient accounts monthly for potential bad debt write-off. These write-offs shall be documented in the Meditech collection notes and shall be reviewed with the facility Controller.

If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible and sent to the collection agency. Reasonable collection efforts include mailing 3 statements and placing at least 1 telephone call.

If the hospital is using a collection agency, an account may not be written off to bad debt until it is returned from the agency.
Medicare deductibles and coinsurance may be written off after receiving Medicare payment if a patient is eligible for Medicaid and these benefits are exhausted (e.g., Medicaid day limit). Must bill and receive "no pay" from Medicaid. Documentation of Medicaid eligibility (for the period in which services were rendered) must be placed in the patient's file or noted on the patient's account. Medicare bad debts shall be written off using the appropriate adjustment code.
For non-Medicare bad debts, balances shall be moved to self-pay "SP" and written-off using the adjustment code "BDWOSP". Accounts should only be written-off to bad debt in cases where the hospital has performed in accordance with contract terms or agreement, has a right to payment, and cannot collect. In cases where a condition of the contract or agreement has been violated (e.g. medical necessity, untimely filing, etc.) the account balance shall be adjusted using a contractual allowance.

If an accounts' denial appeal is upheld, and the CBO and the denial management team determine there is no further action that can be taken, the CBO/designee shall write-off the account by utilizing a denial write-off code appropriate for the type of denial (i.e. no authorization, medical necessity, charge removal, level of care).

XII. Bad Debt Allowances

The KRS Finance Department has established a bad debt allowance policy for all hospitals.

A Bad debt allowance is recorded on each hospital for all accounts receivable before each month is closed.

Exceptions will be granted for cash receipts received before close of the subsequent month on accounts receivables older than 90 days. Cash receipts are pulled from the system on the third work day following Meditech close.

XIII. Revenue Trend Reviews

Quarterly, the KRS Controller shall perform revenue trend reviews to ensure the completeness and accuracy of hospital revenues. Reviews shall be performed at a hospital level with precise enough thresholds to detect material misstatements in revenue.