PALOMAR HEALTH
Rehabilitation Institute

SUBJECT: ACCOUNTS RECEIVABLE

Policy: BO 105
Effective Date: December 22, 2025
Revision Date: December 22, 2025
Review Date: December 22, 2025

Business Office Policies and Procedures

POLICY

The IRF Central Billing Office (CBO) and the IRF Facility are responsible for limiting bad debt, improving cash flow, and mitigating risk for Inpatient Rehabilitation Facility (IRF). The CBO will monitor patient account balances to ensure proper valuation and timely collection.

RESPONSIBILITY

- Sr. Director of Revenue Cycle is responsible for the oversight and managing the department and setting the collection strategy to include agency placements. Also, responsible for engaging Regional Sr. Directors, the facility's Director of Finance, and Staff Accountants as needed to meet key objectives.

- Director of AR is responsible for the day-to-day management of AR and engages the Sr. Director of Revenue Cycle, Regional Sr. Directors, the facilities Director of Finance, and Staff Accountants as needed to meet key objectives.

- Director of AR and/or the Manager will be responsible to assign work to the CBO Rep.

- Director of Finance at the Facility is responsible to complete the monthly close checklist to validate AR, payer classification, and any other errors.

- Director of Finance and Staff Accountant are responsible for follow-up items assigned to the facilities through the Reminder Worklist.

PROCEDURES

The CBO will manage AR through AR aging reports and through the use of the MediTech Reminders Worklist to validate the accuracy, validity of AR balances, and the timely collections of AR. All collection efforts shall be managed through MediTech Reminders Worklist and documented notes in the MediTech system.

The MediTech Reminders Tool is a work queue intended to ensure all Patient accounts are worked, with consistent follow-up. This tool will manage/track collection efforts to improve timeliness, accuracy, and accountability.

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The CBO Director and Manager will assign work to the Patient Financial Service Rep (PFSR) based on either region or payer or both in MediTech. All Patient accounts with balances will be assigned to a PFSR.

The MediTech Reminder Tool will build worklists based on these assignments. The PFSR will sign into the MediTech system daily to access their worklists and manage their AR. Once the work is assigned, the Reminder Tool will assign the accounts to the appropriate worklist that has a balance. The team will manage their worklist in a timely manner as defined by their leadership.

The Staff Accountants and Director of Finances are also required to sign into their Reminder Worklist on a daily basis to work any reminders that have been assigned to them.

PFSRs, Staff Accountants, Director of Finances, and respective leadership can assign and will be assigned work within the MediTech Reminder Tool.

This policy applies to all patient accounts.

Information obtained from income tax returns, paystubs, or the monetary asset documentation collected for the discount payment or charity care elibility determinations cannot be used for collection activities.

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.

Monitor Patient Account Balances

1. The PFSRs will manage their daily worklist to ensure accurate and timely reconciliation of accounts
2. The PFSRs will monitor AR aging and ensures accounts are worked according to the collection strategy
3. The PFSRs may assign work to Staff Accountant, Director of Finances, and Leadership for follow-up items that fall within their areas of responsibilities to resolve
   a. The PFSR should ensure they use the appropriate MediTech "Canned Text" when assigning this work
   b. The Staff Account, Director of Finances, and Leadership should follow

the same guidelines when working Reminders

4. The Collection Strategy may include the following:
   a. The initial follow-up call will be 14 days after the claim submission.
   b. Subsequent follow-up treatment will be based on the type of follow-up and will be made within 14 days.
   c. The Reminder Worklist may be prioritized by past due reminders and based on the balances
   d. The collection team performs collection treatment activities to include telephone calls, electronic mail, and letters based on the collection strategy

Review of Payer Classification

The CBO Director/designee shall determine if payer balances and revenues should be restated via changing the insurance contract data set up and coordinate with the Facility. AR should not be transferred between payers due to changes in payer classification using the Edit Insurance Balance routine. The Edit Insurance Balance routine is only applicable to transfers of coinsurance and deductibles between payers and self-pay.

The Director of Finance shall complete the monthly "close checklist" which is intended to catch any payer classification or other errors.

Documentation of Collection Efforts

The PFSR shall document all collection efforts (telephone calls or letters to and from the 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 the person, title, and phone number with whom Collector has spoken.
- Payment status, including specific details of any missing documentation needed 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 Virtual Patient Financial Folder (VPFF). The VPFF can be found using the following path:

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Knect > LP > CBO Patient Financial Folder > Find Patient

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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 PFSR 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 PFSR will submit reminders with the canned text “Collection Request” and route to either the CBO Director or Sr. Director of Rev Cycle for approval for agency placement. The CBO Director or Director of Rev Cycle will confirm all collection efforts have been exhausted and then will notify the facility of the claims that will be placed with the OCA.

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

Utilization of Corporate Legal and/or Outside Attorney

There may be occasions where the CBO may need legal intervention to assist in the collection of payment from the payer.

Litigation should be initiated after all reasonable efforts to collect have been exhausted. .

In cases where legal action is required, the CBO/designee shall engage Lifepoint Legal Counsel. This form, along with supporting documentation, shall be approved by the DVP Finance/designee for approval. Once approved, the Sr. Director of Revenue Cycle will work with Lifepoint Legal Counsel before proceeding. Lifepoint Legal Counsel may require the assistance from outside counsel to handle the litigation.

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 Director of Finance 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 Director of Finance after MediTech close and before SAP close and saved internal control folder.

Patient refund requests shall be documented on a Patient Refund Form and

submitted to the CBO Director, Sr. Director of Rev Cycle, and Director of Finance for approval before posting in the MediTech system. Refund request authorization levels will follow the IRF Authorization Grid.

- Director of Finances $ 0.01 - $ 250.00
- Sr. Directors of Finance $ 250.01 - $ 1,500.00
- Sr. Director, Revenue Cycle $ 1,500.01 - $10,000.00
- DVP $10,000.01 +

Email/electronic signature shall also suffice for approval on adjustment/refunds, etc. All backup and support for the refund shall be maintained along with a copy of the 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 Director of Finance. The payee's name and address must be correct in the MediTech System before posting the refund.

The CBO Director/designee is responsible for completing the Medicare Credit Balance Report within 30 days after the close of each calendar quarter.

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.

Any payer changes and payment term changes within MediTech if required, should be sent to NetSmart for them to update in the MediTech system. The reasons for payer/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 managed through the MediTech Reminder tool and noted in MediTech. All backup and support shall be maintained along with a copy of the email/electronic signature approval for one year.

Manual adjustment approval requirements will follow the IRF Authorization grid (email/electronic signature shall also suffice for approval).

- Director of Finances $ 0.01 - $ 250.00
- Sr. Directors of Finance $ 250.01 - $ 1,500.00
- Sr. Director, Revenue Cycle $ 1,500.01 - $10,000.00

- DVP $10,000.01 +

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 Sr. Director, Revenue Cycle shall review the MediTech Manual Adjustment Report after closing to ensure posting adjustments are in compliance with the approval limits. A final version of the MediTech Manual Adjustment Report shall be emailed with Sr. Director of Revenue Cycle approval to the CBO Director to be electronically saved after month end 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).

Commercial and Self-Pay Discounts

Payers are assigned specific mnemonics to adjust balances systemically at the time of final billing. Any plan not assigned a specific mnemonic, i.e. self-pay, will be set up with payer-specific contract terms and the balance will be adjusted at the time of the final bill.

Commercial and self-pay discounts shall be approved by the Director of Finance. 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 Director of Finance shall be notified and must approve the discount.

The Director of Finance shall obtain approval from the CEO and DVPF before negotiating discounts in over
$50,000 per account.

Following Medicare regulations, inpatient Medicare co-insurance and deductibles may not be waived.

Identification of Charity Patients

Charity patients should only be accepted from partner hospitals. Patients who may qualify for charity write-offs shall be identified upon admission or before exhaustion of

other payer benefits. See charity care 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 been 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.

Extended Payment Arrangements

Extended payment plans should not exceed six months. However, there may be occasions where payment arrangements will exceed beyond six months. The CBO Director can grant payment plans for up to twelve months. The Sr. Director of Revenue Cycle can approve payment plans up to twenty-four months. Any payment arrangements beyond must be approved by the Director of Finance and DVP Finance. Any approved payment arrangement beyond three months must be documented with the patient by either email or by letter sent via certified or overnight mail.

The Sr. Director of Revenue Cycle 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 Sr. Director of Revenue Cycle will work with Lifepoint Corporate Legal Department regarding potential promissory notes.

The PFSR shall review all accounts under extended payment arrangements monthly to ensure that payments are made per the agreement. If payment is not made, the PFS Rep shall notify the CBO Director for appropriate action. All payment arrangements should be included and monitored in the “Reminder Worklist”.

NOTE: Only the CBO will utilize the following routine to set-up extended payment arrangements: BAR => Process Account => Collections => Contract/Agency • Edit Contract

Bad Debt Write-off Process

Accounts shall not be written off to bad debt until all appropriate collection efforts have been exhausted by the CBO. These write-offs shall be documented in the MediTech by selecting the appropriate Reminder “canned text” and routed to the Facility Director of Finance along with the UB/Medicare EOB and 2nd insurance

remit for documentation.

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 three statements and placing at least one telephone call.

An account may not be written off to bad debt until it is returned from the OCA if applicable

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 scanned into the patient’s VPFF account and noted in MediTech.
Medicare bad debt shall be written off using the appropriate adjustment code.

For non-Medicare bad debt, 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 per 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 the correct contractual allowance.

If an accounts’ denial appeal is upheld, and the hospital Director of Finance/CBO and the denial management team determine there is no further action that can be taken, the hospital Director of Finance/CBO Director/designee shall utilize a denial write-off code appropriate for the type of denial (i.e. no authorization, medical necessity, charge removal, level of care). The write-off will be submitted for approval following the IRF Authorization Grid.

Bad Debt Allowances

Bad debt for Lifepoint IRFs are calculated using one consistent bad debt grid, there are no specific bad debt allowances. All account receivables are reserved using the below methodology:

Unbilled/Current	2%
0-60 Days Past Due	2%
61-120 Days Past Due	3%
121-180 Days Past Due	10%
181-240 Days Past Due	25%
241-300 Days Past Due	50%
301-360 Days Past Due	75%
361+ Days Past Due	100%

Quarterly, the LP SVP CFO and LP DVP Director of Finance review a summary prepared by the Sr. Director of IRF Accounting of IRF bad debt allowances for reasonableness. The schedule includes a four-quarter trend of bad debt as percentage of total trade AR. A schedule is also prepared to re-

perform the bad debt expense is in accordance with the bad debt grid. The review is documented by approved schedules that are maintained by the LP Director of Finance in the LP Audit and SOX folders.

Annually, the Sr. Director of IRF Accounting performs an analysis of cash collections on receivable balances and compares results to the current aging methodology to assess the adequacy of current reserve for doubtful accounts, also referred to as the hindsight analysis.

Exceptions will be granted for cash receipts received before the close of the subsequent month on accounts receivables older than 90 days.

Revenue Trend Reviews

Quarterly, the LP Director of Finance 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.