POLICY AND PROCEDURE

DEPARTMENT: Revenue Cycle		DATE ORIGINAL EFFECTIVE: Not Set
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Policy Statement

After our patients have received services, it is the policy of Barton Health to bill patients and their applicable payers in a timely and accurate basis. During this billing and collection process, staff will be committed to providing quality customer service and appropriate follow-up on all outstanding accounts.

Purpose

It is the goal of this policy to provide a clear and consistent procedure for conducting billing and collections functions in a manner that promotes compliance, patient satisfaction, and efficiency. Using billing statements, written correspondence, and phone calls, Barton Health will strive to make diligent efforts to inform patients of their financial responsibilities and available financial assistance options, as well as follow up with patients regarding outstanding accounts. Additionally, this policy requires Barton Health to make reasonable efforts to determine a patient's eligibility for financial assistance under Barton Health's financial assistance policy before engaging in extraordinary collection actions to obtain payment.

Billing Practices

Barton Health will strive to bill all claims accurately and on a timely basis. Although dependent on information and communication from patients and payers, Barton Health will provide enough follow-up service to ensure that patients receive an accurate account and billing information and

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can make payment and/or apply for Financial Assistance. The billing process will be assisted by the following guidelines:

1. For all insured patients, Barton Health will bill all third party payer information (as provided by or verified by the patient) on a timely basis.
2. If a claim is denied (or is not processed) by a payer due to a Barton Health error, Barton Health will not bill the patient for any amount in excess of that for which the patient would have been liable had the payer paid the claim.
3. If a claim is denied (or is not processed) by a payer due to factors outside of Barton Health's control, hospital staff will follow up with the payer and patient as appropriate to facilitate the resolution of the claim. If resolution of the claim does not occur after reasonable follow-up efforts, Barton Health may bill the patient or take other actions consistent with current industry standards.
4. After claims are processed by payers, Barton Health will bill patients on a timely basis for their respective liability amounts as determined by their payers.
5. All patients may request an itemized statement for their accounts at any time.
6. All billed patients will have the opportunity to contact Barton Health regarding Financial Assistance for their accounts. Financial assistance may include charity care, payment arrangements, or other applicable programs.
7. Barton Health will approve payment arrangements for patients whereby the patient pays the greater of $50 or 10% of the original patient balance per month. Barton Health's Billing Managers and Director have the authority to make exceptions to this policy on a case-by-case basis for special circumstances. Barton Health is not required to accept patient-initiated payment arrangements and may refer accounts for collection if the patient is unwilling to make acceptable payment arrangements or has defaulted on a Barton Health approved payment plan.
8. Through the use of billing statements, letters and phone calls, Barton Health will take diligent follow-up actions to contact patients to resolve outstanding accounts. If accounts are not resolved during this process, the outstanding balances may be referred to a third-party agency or attorney for collection at the discretion of Barton Health.

Collection Practices

In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Billing and Collections Policy, Barton Health may engage in collection activities including extraordinary collection actions (ECAs) to collect outstanding patient balances.

1. General collection activities may include [follow-up calls on statements]
2. Patient balances may be referred to a third party for collection at the discretion of Barton Health. Accounts will be referred for collections only with the following caveats:

    - There is a reasonable basis to believe that the patient owes the debt.
    - All third-party payers have been properly billed by Barton Health and the remaining debt is the financial responsibility of the patient. Hospital shall not bill a patient for any amount that an insurance company is obligated to pay.

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- Barton Health will not refer accounts for collection while a claim on the account is still pending payer payment. However, Barton Health may classify certain claims as "denied" if such claims are stuck in "pending" mode for an unreasonable length of time despite Barton Health's efforts to facilitate resolution.
- Barton Health will not refer accounts for collection where the claim was denied due to a Barton Health error.
- Barton Health will not refer accounts for collection where the patient has initially applied for Financial Assistance or other Barton Health sponsored program and Barton Health has not yet notified the patient of its determination (provided the patient has complied with the timeline and information requests delineated by Barton Health during the application process).

Reasonable Efforts and Extraordinary Collection Actions (ECAs)

Before engaging in ECAs to obtain payment for care, Barton Health Hospital must make certain reasonable efforts to determine whether an individual is eligible for financial assistance under our financial assistance policy:

1. ECAs may begin only when 120 days have passed since the first post-discharge statement was provided. However, at least 30 days before initiating ECAs to obtain payment, Barton Health shall do the following:

    - Provide the individual with a written notice that indicates the availability of financial assistance, lists potential ECAs that may be taken to obtain payment for care and gives a deadline after which ECAs may be initiated.
    - Provide a plain-language summary of the FAP, along with the notice described above.
    - Attempt to notify the individual orally about the FAP and how he or she may get assistance with the application process.

2. After making reasonable efforts to determine financial assistance eligibility as outlined above, Barton Health (or its authorized business partners) may take the following ECA to obtain payment for care:

    - Report adverse information to credit reporting agencies and/or credit bureaus.
    - Litigation.

3. If a patient has an outstanding balance for previously provided care, Barton Health may engage the ECA process for deferring, denying, or requiring payment before providing additional medically necessary (but non-emergent) care only when the following steps are taken:

    - Barton Health provides the patient with a FAP application and a plain language summary of the FAP.

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- Barton Health provides a written notice indicating the availability of financial assistance and specifying any deadline, after which a completed application for assistance for the previous care episode will no longer be accepted. This Application period is the later of 30 days after the notice date or 240 days after the first post-discharge billing statement for prior care, whichever is later.
- Barton Health makes a reasonable effort to orally notify the individual about the financial assistance policy and explain how to receive assistance with the application process.
- Barton Health processes on an expedited basis any FAP applications for previous care received within the stated deadline.
- Final authority in determining whether an individual is FAP- eligible will be made by the financial assistance committee. The committee includes but is not limited to the CFO, the Revenue Cycle Director, the Manager of Patient access, the Manager(s) of Patient Financial Services, the Patient Access Supervisor, and the Financial Counselor.
- If an application for Financial Assistance is received but is incomplete, a letter will be sent to the patient outlining what is missing from the application. The application will be pended for two weeks to allow time for response. If the additional information is not received within two weeks, Barton will send a denial letter to the patient stating that the application was not complete and the missing information was not received

Financial Assistance

All billed patients will have the opportunity to contact Barton Health regarding financial assistance for their accounts, payment plan options, and other applicable programs.

1. Barton Health's financial assistance policy is available free of charge.

Request a copy:

- In person at any registration location at Barton Health.
- By calling the Customer Service Department: 530-543-5930 or the Financial Counselor: 530-539-6086
- By mailing a written request to Barton Health Attn: Financial Counselor 2170 South Ave. South Lake Tahoe, CA 96150
- Via e-mail to: financialassistance@bartonhealth.org
- Online at https://www.bartonhealth.org/tahoe/financial-aid.aspx

2. Individuals with questions regarding Barton Health's financial assistance policy may contact the financial counseling office by phone at 530-543-5930 or in person at 2170 South Avenue, South Lake Tahoe, CA 96150.

Customer Service

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BILLING AND COLLECTION POLICY

During the billing and collection process, Barton Health will provide quality customer service by implementing the following guidelines:

1. Barton Health will enforce a zero-tolerance standard for abusive, harassing, offensive, deceptive, or misleading language or conduct by its employees.
2. Barton Health will maintain a streamlined process for patient questions and/or disputes, which includes a phone number patients may call and a prominent business office address to which they may write. This information will remain listed on all patient bills and collection statements sent by Barton Health.
3. After receiving a communication from a patient (by phone or in writing), Barton Health staff will return phone calls to patients as promptly as possible (but no more than one business day after the call was received) and will respond to written correspondence within ten business days.

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