Barnabas Health
Recommended Procedure

Policy # PA 288
Effective Date: 12/16/2015

Policy Title: Billing and Collections Procedure

APPROVED BY: (Signature) ______________________ **DATE:** ___________

(Title) Barnabas Health – Vice President of Revenue Cycle

PURPOSE: The purpose of this policy is to ensure that the Barnabas Health (BH) Centralized Business Office (CBO) establishes guidelines and controls with respect to billing and collections. This policy along with the Financial Assistance Policy is intended to meet the requirements of applicable federal, state and local laws including and without limitation section 501r of the Internal Revenue Code of 1986, as amended and its implementing regulations.

POLICY: It is the policy of the Barnabas Health (BH) Centralized Business Office (CBO) to ensure that all billing and collection efforts follow a standard protocol from the time claims are final billed.

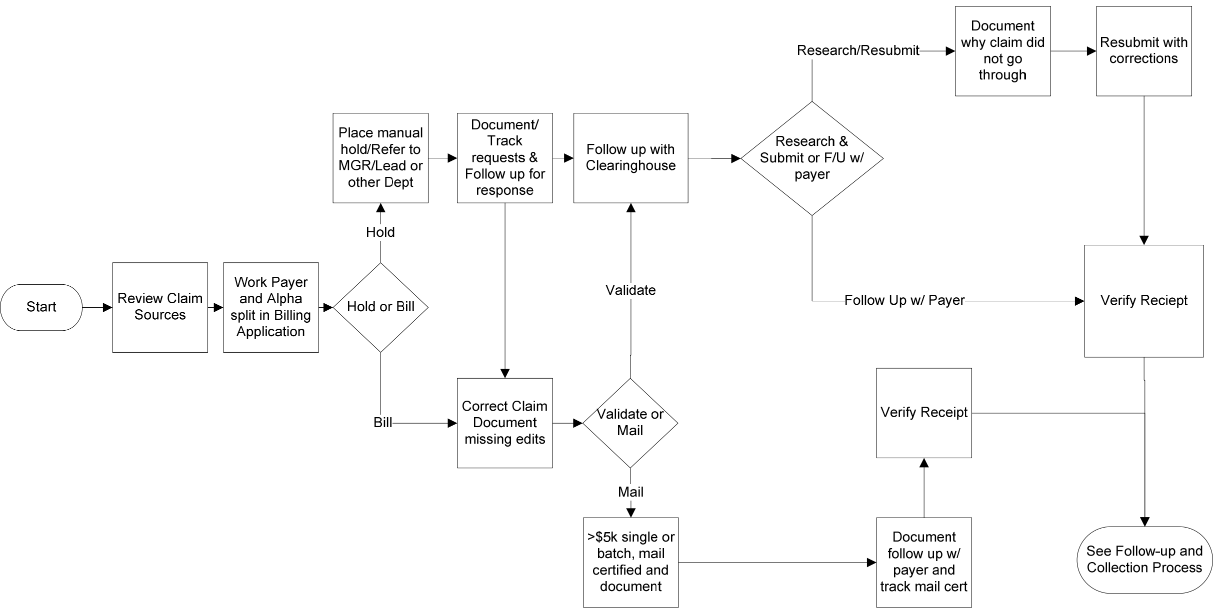
RESPONSIBLE PARTY: CBO Management, Vendor Partner Management

PROCEDURE NARRATIVE:

INSURANCE BILLING PROCEDURE:
The Hospital shall request payment for any known patient responsibility for medical care prior to or at the time of service. With respect to emergency care, the hospital will request payment of any known patient responsibility after care is provided, patient is stabilized and as part of discharging the patient from the emergency department.

Insurance billing commences by using the electronic Claim Management tool (XClaim), claims are worked by Patient Account Representatives (PARs) based on Payer, Hospital, and/or claim type assignment. Where necessary, claims are routed accordingly for additional billing information as required prior to billing.

Example Best Practice Process Flow:



The CBO and the individual Sites maintain an up-to-date claim routing grid to ensure timely resolution of inquiries prior to claim submission.

INSURANCE REBILL PROCEDURE:

Prior to generating a rebill, the PAR will verify in XClaim to see if the original claim was submitted to the payer.

If the original claim has not been submitted to the payer, the designated PAR will delete the claim and order a rebill (XX1) in the host (Affinity or SM) using the “Rebill” steps indicated in the insurance rebill job aide.

If the original claim has been submitted to the payer the designated PAR will order a rebill (XX7) in the host (Affinity or SMS) using the “Rebill” steps indicated in the insurance rebill job aide.

INSURANCE FOLLOW-UP GUIDELINES:

Medicare and Medicaid:

Follow Up(# of days)	Less than $10K	Over $10K
M.R. initial request	30	14
M.R. follow up	14	14
Billing request Flag	5	5
EOB Flag	14	14
Claim in process	14	14
Reprocess	Electronic 14/DDE 14/Hardcopy 30	14
Secondary Claim	Electronic 14 /DDE 14/Hardcopy 30	14
Additional info from pt needed e.g.COB	5	5
When we send a fax	30	14
Rebill/insurance update	3	3
Left message…All Payers	3	3
Billing NDC Request	14	14
Request to Site for additional Info	14	7
Cash App Research	5	5

Non-Federal:

Follow Up(# of days)	Less than $5K	Over $5K but less than $20K	Over $20K
M.R. initial request*	30	30	14
M.R. follow up*	30	30	14
Billing request Flag*	30	30	14
EOB Flag*	30	30	14
Claim in process*	30(from claim rec'd)	30(from claim rec'd)	14
Reprocess*	30	30	14
Secondary Claim*	30	30	14
Additional info from pt needed e.g.COB*	7	7	7
When we send a fax**	3	3	3
Rebill/insurance update*	3	3	3
Left message…All Payers*	3	3	3
Check in the mail*	30	30	14
Billing NDC Request*	30	30	14

*Follow normal collection/follow-up flow
**Fax. While on the phone and try to confirm receipt

<u>SELF PAY BILLING AND COLLECTIONS PROCEDURES</u>:

Barnabas Health treats all patients equally regardless of insurance and their ability to pay.

For accounts determined to be "self-pay" and/or accounts with balance after primary insurance, the following action will take place. **If at any point during this process, if it is determined that a patient**

qualifies for Financial Assistance, or if other insurance information is obtained, that insurance payor or program is billed. Collection efforts include:

1. Series three(3) statements
2. A minimum of one(1) Final Notice
3. Telephone contact on any account over $24.99.
4. For all returned mail, attempts are made to locate a corrected address and correspondence is send to that address. If a corrected address cannot be located, telephone contact continues to be the primary method of contact.
5. Patients are given the option to enter into a monthly payment arrangement if they are unable to pay their bill in full. Payment arrangements will not exceed a twelve month period unless approved. Upon entering a payment arrangement, patients will receive monthly statements for agreed upon amount.

Financial Assistance:

If a patient's financial situation changes for any reason, they may contact customer service, the hospital or via the website obtain the Financial Assistance Policy (FAP), the FAP Application and FAP Plain Language Summary to complete the process to determine if they qualify for any discounted care. (Please see FAP for all details specific to the current policy in force).

Uninsured Population:

All uninsured patients are encouraged to complete the FAP application process and are encouraged to discuss their qualifications for other programs that may cover them for a portion or all of their health care. These patients will only be billed the lessor of 115% of Medicare or the Amount Generally Billed (AGB) as described in the FAP.

In the event uninsured patients do not complete the FAP process, all uninsured accounts are run through a PARO process to determine whether they would have qualified had they completed the FAP application. These accounts when qualified via PARO will be written off 100% and will not be pursued under the Bad Debt process.

BAD DEBT QUALIFICATION:

Barnabas Health treats all patients equally regardless of insurance and their ability to pay. Service medically necessary emergent services are never refused a patient due to any financial criteria.

Accounts with a patient balance where debt remains unpaid for more than 120 days from the date the first bill is mailed to the beneficiary, and is deemed uncollectible, will be transferred to a bad debt status in the host system.

These accounts have exhausted the normal collection flow as stated below:

1. Four (4) statements are sent to the patient reflecting accurate balances.
2. One (1) phone contact attempt
3. Default of payment plan agreement within 1 month of the breech.

The account transfer to bad debt process may be accelerated if any of the following occur:

1. Mail is returned from the guarantor address on file and no updated address is obtainable.
2. The guarantor has refused to payor defaults on a pre-arranged payment schedule.
3. The guarantor is deceased.

Any other situation or occurrence that would reasonably eliminate the expectation of payment.

PROHIBITED COLLECTIONS ACTIVITY:
It is the policy of Barnabas Health to treat all patients with dignity regardless of their ability to pay. As such, the following collection efforts are prohibited by all sources:

- Referring or Selling of Debt, or credit reporting.
- Denying or deferring care based on current past due or prior unpaid debt
- Liens, Writs of Body Attachment, Wage Garnishment
- Any other extraordinary actions without written consent of Barnabas Health

EQUIPMENT: Host Systems, XClaim

QUALIFICATIONS/JOB AIDE REFERENCE: Federal and Non-Federal Billing Guidelines and internal department protocols

ORIGINAL DATE: 4/1999

REVIEWED: 3/3/2015

REVISED: 12/16/2015

Approved By: ____ **Date:** __________________