LOMA LINDA UNIVERSITY
MEDICAL CENTER – MURRIETA

LOMA LINDA UNIVERSITY MEDICAL CENTER-MURRIETA

OPERATING POLICY

CATEGORY:	FINANCE	**CODE:**	M-C-55
		EFFECTIVE:	05/2025
SUBJECT:	BILLING AND DEBT COLLECTIONS	**REPLACES:**	12/2024
		PAGE:	1 of 10

PURPOSE:

This policy applies to Loma Linda University Medical Center-Murrieta (hereinafter collectively "LLUMC-M").

The Billing & Debt Collection Policy (BDCP), together in coordination with the LLUMC-M Financial Assistance Policy (FAP), is intended to meet the requirements of applicable federal, state and local laws, including and without limitation, Section 501(r) of the Internal Revenue Code, California Health and Safety Code Sections 127400 – 127446, as amended, and 22 CCR Section 96051 et. seq.

The BDCP applies to all patients and/or responsible parties who receive hospital medical care at LLUMC-M. The guiding principles behind this policy are to treat all patients and individuals responsible for payment equally, with dignity and respect. All requests for payment arrangements from patients, patient families, patient financial guarantors, physicians, hospital staff, or others shall be addressed in accordance with this policy.

This policy defines the requirements and processes used by the LLUMC-M Patient Business Office when making arrangements with patients or individuals responsible for payment of a bill for services rendered. The BDCP is designed to ensure appropriate billing and collection procedures are uniformly followed, including reasonable efforts to determine whether the individuals responsible for payment of all or a portion of a patient account are eligible for assistance under the FAP. This policy also defines the standards and practices used by LLUMC-M for collection of debts arising from nonpayment for hospital medical care provided by LLUMC-M, including but not limited to extraordinary collection actions (ECA).

LLUMC-M will not deny emergency or other medically necessary care based on a patient's ability to pay.

DEFINITION OF TERMS

Authorized Vendors: Those vendors LLUMC-M may contract with to produce and send letters, notices, bills and/or other statements to patients/guarantors regarding amounts owed by the patient/guarantor and to contact the patient regarding payment of their unpaid bills.

Discharge Notice: A summary of the FAP that is easy to read, easy to understand and easy to

use. Information is provided on where to find help paying your bill, the availability of LLUMC-M Charity and Discounted Care policies and how to apply for financial assistance offered by LLUMC-M and government programs. Contact information on where to obtain more information is included in the Discharge Notice.

Extraordinary Collection Actions (ECAs): Actions taken by LLUMC-M against an individual related to obtaining payment of a bill for care that require a legal or judicial process as specified by federal and/or state law, including some liens, foreclosures on real estate, attachments/seizures, commencing civil action, causing an individual to be subject to a writ of attachment, and garnishing an individual's wages. ECAs do not include any lien that a hospital is entitled to assert under state law on the proceeds of a judgment, settlement or compromise owed to a patient/guarantor as a result of personal injuries for which a hospital provided care.

Financial Assistance Policy (FAP): The LLUMC-M policy for the provision of financial assistance for eligible patients/guarantors who are in need of financial assistance.

Internal Revenue Code 501(r): Includes regulations that apply to charitable hospitals.

Medical Debt: Means a debt owed by a consumer to LLUMC-M or its agent or assignee, for the provision of medical services, products or devices. Medical debt includes, but is not limited to, medical bills that are not past due or that have been paid. Medical service, product or device does not include cosmetic surgery. However, reconstructive surgeries and follow-up care, initial or subsequent prosthetic devices, and mastectomy are included under this definition.

Medically Necessary Care: Healthcare services as defined by California Welfare & Institutions Code §14059.5. A service is medically necessary or a medical necessity when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. In the event that the hospital determines a particular service is not medically necessary, the referring physician and/or the supervising health care provider must sign an attestation indicating the rationale for determining the hospitals service(s) as not medically necessary. Said attestation must be completed prior to the denial of full or partial financial assistance by LLUMC-M.

PATIENT BILLING POLICY & PROCEDURES:

A. LLUMC-M and the patient/guarantor share responsibility for timely and accurate resolution of all patient accounts. Patient/guarantor cooperation and communication is essential to this process. LLUMC-M will make reasonable, cost-effective efforts to assist patients/guarantors with fulfillment of their financial responsibility.

B. The LLUMC-M Patient Business Office is primarily responsible for the timely and accurate collection of all patient/guarantor accounts. Patient Business Office personnel work cooperatively with other hospital departments, members of the medical staff, patients/guarantors, insurance companies, collection agencies and others to assure that timely and accurate processing of patient/guarantor accounts can occur.

C. Initial debt collection is conducted by the LLUMC-M Patient Business Office. The Authorized Vendor collection agencies provide approved specific secondary debt collection services in compliance with written contracts between LLUMC-M and the Authorized Vendors.

D. Information obtained as part of the LLUMC-M financial assistance eligibility determinations will not be used by LLUMC-M or its Authorized Vendors for debt collection purposes.

E. Accurate information provides the basis for LLUMC-M to correctly bill patients/guarantor or their insurer. Patient billing information should be obtained in advance of hospital services whenever possible so that verification, prior authorization or other approvals may be completed prior to the provision of services. When information cannot be obtained prior to the time of service, hospital personnel will work with each patient/guarantor to assure that all necessary billing information is received by LLUMC-M prior to the completion of services.

F. It is the obligation of every patient/guarantor to provide a correct mailing address, telephone number and other required information for patient registration at any LLUMC-M service point. Such information shall be updated by the patient or guarantor in the event that they move or if there are other changes to the information previously provided.

G. Medical care at LLUMC-M is available to those who may be in need of medically necessary services. To facilitate financial arrangements for persons who may be of low or moderate income, both those who are uninsured or underinsured, LLUMC-M provides the following information to patients/guarantors as part of the routine billing process:

1. A written statement of charges for services rendered by the hospital provided in a format which shows the patient a synopsis of all charges for services rendered. Upon patient/guarantor request, a complete itemized statement of charges will be provided.

2. A written request that the patient/guarantor inform LLUMC-M if the patient/guarantor has any health insurance coverage, Medicare, Medi-Cal or other form of insurance coverage.

3. A written statement informing the patient/guarantor that they may be eligible for Medicare, Medi-Cal, California Children's Services Program, health plans available through Covered California or the LLUMC-M Financial Assistance Program.

4. A written statement indicating how the patient/guarantor may obtain an application for Medi-Cal, health plans available through Covered California, or other appropriate government coverage program.

5. If a patient/guarantor is uninsured, an application to Medi-Cal, health plans available through Covered California, or other appropriate government assistance

program will be provided. Trained LLUMC-M staff is available at no cost to the patient to assist with application to relevant government assistance programs.

6. A written statement regarding eligibility criteria and qualification procedures for Charity and/or Discounted Care under the LLUMC-M Financial Assistance Program. This statement shall include the name and telephone number of hospital personnel who can assist the patient/guarantor with information about and an application for the LLUMC-M Financial Assistance Program.

7. Uninsured patients will also be provided contact information for local consumer legal assistance programs which may assist the uninsured patient with obtaining coverage.

8. Help Paying Your Bill

   8.1 There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

H. LLUMC-M provides financial counselors to assist uninsured patients with evaluating potential options for financial coverage of services provided at LLUMC-M. Financial counselors will assist the patient/guarantor with applications for government coverage programs, LLUMC-M financial assistance applications, and/or other possible options to help the uninsured patient/guarantor seek financial coverage which may be available to them.

I. Eligibility for Charity or Discounted Care under the FAP shall be determined at any time LLUMC-M is in receipt of relevant income information from the patient/guarantor. There is no time limit for applying for Charity or Discounted Care, and LLUMC-M will not deny a patient/guarantor's eligibility based on the timing of an application.

J. If a patient/guarantor is attempting to qualify for eligibility under the FAP and is attempting in good faith to settle an outstanding bill with LLUMC-M by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, LLUMC-M will not send the account to any Authorized Vendor unless it agrees to comply with Health and Safety Code sections 127400 through 127446, inclusive.

K. Each patient's/guarantor's account will be assigned to an appropriate Patient Business Office representative based upon established criteria and staff workloads. Once a patient/guarantor account is assigned to a Patient Business Office representative, the account details will be reviewed to assure accuracy and completeness of information necessary for the account to be billed.

L. If the account may be payable by the patient's/guarantor's insurer, the initial claim will be forwarded directly to the designated insurer. LLUMC-M Patient Business Office personnel will work with the patient's/guarantor's insurer to obtain any or all amounts owed on the

account by the insurer. This will include calculation of contracted rates or other special arrangements that may apply. Once payment from the primary insurer has been determined by LLUMC-M, any secondary or tertiary payers will have claims filed by LLUMC-M on behalf of the patient/guarantor.

M. Once all insurance claims on an account have been resolved, any residual patient/guarantor liability balance, for example a co-payment or deductible amount, will be billed directly to the patient/guarantor. Any or all patient/guarantor balances are due and payable within 30 days from the date of this first bill.

N. If there are no insurance claims to be filed and the account is payable only by the patient/guarantor, it will be classified as a Self-pay account. Self-pay accounts may potentially qualify for government coverage programs, financial aid under the LLUMC-M FAP, or other policy discounts. Patients/guarantors with accounts in Self-pay status should contact a Patient Business Office representative to obtain assistance with qualifying for one or more of these options.

O. In the event that a patient/guarantor has made a deposit payment, or other partial payment for services and it is subsequently determined that the patient qualifies for full Charity Care or Discounted Care, all deposits paid which exceed the payment obligation, if any, as determined through the Financial Assistance process, shall be refunded to the patient/guarantor with interest within 30 days from the date the payment was received by the hospital. Interest shall begin to accrue on the first day that payment by the patient/guarantor is received by the hospital. Interest amounts shall accrue at Ten Percent (10%) per annum. In the event that the amount of interest owed to the patient/guarantor as part of a refund is less than Five Dollars ($5.00), no interest will be paid to the patient/guarantor. The hospital will not reimburse the patient if the hospital determines that a patient qualified for financial assistance at the time the patient was first billed and if it has been five years or more since the last payment to the hospital or hospital assignee.

P. LLUMC-M, and any of its Authorized Vendors, shall **NOT** furnish any information related to patient/guarantor medical debt to any consumer credit reporting agency.

Q. LLUMC-M may require a patient/guarantor to pay the hospital the entire amount of any reimbursement sent directly to the patient/guarantor by a third-party payer for LLUMC-M services.

R. If a patient/guarantor receives a legal settlement, judgment, or award under a liable third-party action that includes payment for LLUMC-M services related to the injury, LLUMC-M may require the patient/guarantor to reimburse LLUMC-M for the related health care services rendered up to the amount reasonably awarded for that purpose.

S. After insurance claims are resolved and/or if there are no insurance claims to be filed, all accounts, whether insured or uninsured will follow and complete the same processes for collection of patient balances due LLUMC-M.

T. Account amounts due from patients/guarantors will not be forwarded to collection status when the patient/guarantor makes reasonable efforts to communicate with LLUMC-M Patient Business Office representatives and makes good faith efforts to resolve the outstanding account. LLUMC-M Patient Business Office will determine if the patient/guarantor is continuing to make good faith efforts to resolve the account due LLUMC-M and may use indicators such as: application for Medi-Cal or other government programs; application for the LLUMC-M FAP; regular partial payments of a reasonable amount; negotiation of a payment plan with LLUMC-M; and other such indicators that demonstrate the patient's/guarantor's effort to fulfill their payment obligation.

U. Patient/guarantor account balances in Self-pay status will be considered past due after 30 days from the date of first post-discharge bill. The Assistant Vice-President of the Patient Business Office or his/her designee shall implement procedures for compliance with the FAP. Accounts may only be advanced for collections in compliance with established procedures. Prior to being advanced to collection status, Self-pay accounts must receive: 1) a written statement of charges; 2) a request that the patient inform LLUMC-M of any insurance coverage that may apply to the account; 3) information about government financial assistance including Medi-Cal or a county program, or Covered California application; 4) information about the LLUMC-M Financial Assistance Program, hospital financial counselor contacts and a program application; 5) local consumer assistance center contact information.

V. LLUMC-M does **NOT sell debt** for collection purposes. Prior to debt collection by the hospital or its Authorized Vendors, LLUMC-M will send the patient/guarantor a written notice with all of the following: 1) the date or dates of service of the bill that is being assigned to collections; 2) the name of the entity the bill is being assigned to; 3) a statement informing the patient/guarantor how to obtain an itemized bill from the hospital; 4) the name and plan type of the health coverage for the patient on record with the hospital at the time of services, or a statement that the hospital does not have that information; 5) an application for the Financial Assistance Program; and 6) the date or dates the patient was originally sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made.

W. Unless a Qualified Payment Plan under the FAP is in place, accounts may be advanced to secondary collection status and referred to an Authorized Vendor after 130 days from the issuance of the first billing statement. **No consumer credit reporting will occur**, and ECAs will not be initiated until after 180 days from the date of the first billing statement issued, and all of the following have occurred:

1. The patient/guarantor has not communicated with LLUMC-M or its Authorized Vendor within the past 60 days;

2. A minimum of four-cycle statements showing billing details at a summary level have been sent to the patient/guarantor, and

3. Notice has been provided to the patient/guarantor that payments have not been made in a timely manner, and the account will be subject to ECAs in 10 days from the notice date.

X. After 30 days or anytime when an account otherwise becomes past due and subject to internal or external collection, LLUMC-M will provide every patient/ guarantor with written notice in the following form:

1. **"State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (382-4357) or online at Federal Trade Commission."**

2. **Non-profit credit counseling services may be available in the area. Please contact the LLUMC-M Patient Business Office if you need more information or assistance in contacting a credit counseling service.**

3. **HELP PAYING YOUR BILL**
There are free consumer advocacy organizations that will help you understand the billing and payment process. You may call the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information.

Y. LLUMC-M offers patients/guarantors an extended payment plan option when they are not able to settle the account in one lump sum payment. Extended payment plans are established on a case-by-case basis through consideration of the total amount owed by the patient/guarantor to LLUMC-M and the patient's/guarantor's financial circumstances. Extended payment plans generally require a minimum monthly payment of an amount such that the term of the payment plan shall not exceed twelve (12) months. Once an extended payment plan has been agreed to by the patient/guarantor, failure to make all consecutive payments due during any 60-day period will constitute a payment plan default. Written notice of extended payment plan default will be provided to the patient/guarantor. It is the patient/guarantor's responsibility to contact the LLUMC-M Patient Business Office if circumstances change and payment plan terms cannot be met.

Z. Certain patients/guarantors who have qualified for LLUMC-M Discounted Care are eligible for a Qualified Payment Plan as described in the LLUMC-M FAP. Qualified Payment Plans involve negotiation between the hospital and patient/guarantor and may result in a payment plan term which exceeds twelve (12) months. Qualified Payment Plans may be arranged by contacting a LLUMC-M Patient Business Office representative. Qualified Payment Plans are free of any interest charges. Once a Qualified Payment Plan has been approved by LLUMC-M, any failure to pay all consecutive payments due during any 90-day

period will constitute a payment plan default. It is the patient/guarantor's responsibility to contact the LLUMC-M Patient Business Office if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default, LLUMC-M will make a reasonable attempt to contact the patient/guarantor by telephone and also give notice of the default in writing. The patient/guarantor shall have an opportunity to renegotiate the payment plan and may do so by contacting a Patient Business Office representative within Fourteen (14) Days from the date of the written notice of payment plan default. If the patient/guarantor fails to request renegotiation of the extended payment plan within Fourteen (14) Days, the payment plan will be deemed inoperative and the account will become subject to collection.

AA. For all patient/guarantor accounts where there is no 3rd party insurer, the Patient Business Office representative will assure that the patient/guarantor has been provided all elements of information as listed above in G, parts (1) through (8). This will be accomplished by sending a written billing supplement with the first patient/guarantor bill. The Patient Business Office representative will document that the billing supplement was sent by placing an affirmative statement in the "notes" section of the patient's/guarantor's account.

BB. LLUMC-M will only utilize Authorized Vendors with which it has established written contractual agreements. Every Authorized Vendor performing services on behalf of LLUMC-M must agree to comply with the terms and conditions of such contracts, which shall include the requirement to comply with the standards and practices contained in the BDCP, FAP, and all legal requirements including those specified in the California Health & Safety Code and Internal Revenue Code Section 501(r). Such requirements include, but are not limited to: 1) returning accounts to the hospital if the balance has been determined to be incorrect due to the availability of a third-party payer, or the patient may be eligible for Charity or Discounted Care; 2) compliance with the hospital's definition and application of a reasonable payment plan; 3) not reporting adverse information to a consumer credit reporting agency; 4) not commencing civil action against the patient/guarantor for non-payment before 180 days after initial billing; 5) not using wage garnishments or liens on any real property when the patient/guarantor is eligible under the FAP.

CC. Any contract entered into by LLUMC-M related to the assignment of medical debt shall require the assignee and any subsequent assignee to maintain records related to litigation for a period of no less than five (5) years.

DD. LLUMC-M shall maintain all records relating to money owed to the hospital by a patient or a patient's guarantor for five years, including but not limited to, all of the following: 1) documents related to litigation filed by the hospital; 2) a contract and significant related records by which the hospital assigns medical debt to a third-party; 3) a list, updated at least annually, of every person, including the person's name and contact information, that is either: a) a debt collector to whom the hospital assigned a debt owed the hospital by a patient/guarantor; and b) a person retained by the hospital to pursue litigation for debts owed by a patient/guarantor on behalf of the hospital.

EE. At least thirty days (30) prior to initiating any ECAs, LLUMC-M or its Authorized Vendors will:

1. Provide the patient/guarantor with a summary of the LLUMC-M FAP;

2. Make an oral attempt to contact the patient/guarantor via telephone at the last known patient/guarantor telephone number; and

3. Provide the patient/guarantor with written notification of the ECAs which LLUMC-M or its Authorized Vendor intends to initiate to obtain payment for care rendered to the patient.

FF. In accordance with the LLUMC-M FAP, a patient may submit an application for LLUMC-M financial assistance at any point during the revenue cycle. LLUMC-M or its Authorized Vendors may identify a patient/guarantor potentially eligible for financial assistance in accordance with the LLUMC-M FAP. In the event that a financial assistance application is received by LLUMC-M or any Authorized Vendor subsequent to initiation of ECAs, LLUMC-M or its Authorized Vendor shall immediately suspend enforcement of ECAs. During the period of ECA suspension, LLUMC-M shall make reasonable efforts to determine whether the patient/guarantor is eligible for financial assistance under the FAP. Patients/guarantors must make reasonable efforts to provide accurate information when completing the Financial Assistance Application. LLUMC-M at its sole discretion, but no sooner than thirty (30) days from the start of suspension of ECAs, may determine if the patient/guarantor has made reasonable efforts to cooperate with the LLUMC-M Financial Assistance Application process. Collection activity may resume in the following situations:

1. The patient/guarantor fails to cooperate with the Financial Assistance Application process; or

2. LLUMC-M determines that the patient/guarantor is not eligible for financial assistance under the FAP.

GG. If a patient/guarantor has filed an appeal for coverage of services, LLUMC-M will extend the 180-day period prior to commencing any civil action or other ECAs until a final determination of the pending appeal has been made. Patient appeals may include:

1. a grievance against a contracting health plan;

2. seeking an independent medical review;

3. a fair hearing for a review of a Medi-Cal claim pursuant to California requirement; and

4. an appeal regarding Medicare coverage pursuant to federal law and regulation;

HH. LLUMC-M and/or its Authorized Vendors will not use wage garnishments or liens on a primary residence without a valid court order. Any or all legal

action to collect an outstanding patient/guarantor account by LLUMC-M and/or its Authorized Vendors must be authorized and approved in advance, in writing, by the Patient Business Office Assistant Vice-President or the Vice-President of Revenue Cycle. Any legal collection action must conform to the requirements of the California Health & Safety Code and Internal Revenue Code Section 501(r). LLUMC-M, its Authorized Vendors, or any assignee may use any or all legal means to pursue reimbursement, debt collection and any enforcement remedy from third-party liability settlements, tortfeasors, or other legally responsible parties. Such actions shall be conducted only with the prior written approval of the Patient Business Office Assistant Vice-President or the Vice-President of Revenue Cycle.

II. Bill Complaint Program

1. The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

2. If LLUMC-M receives notice that a patient/guarantor has filed a complaint with the Hospital Bill Complaint Program, it shall not send the patient/guarantor's account to any Authorized Vendor unless the Authorized Vendor agrees to comply with Health and Safety Code sections 127400 through 127446, inclusive.

APPROVERS: Executive Committee, LLUMC-M Board, LLUMC-M Chief Executive Officer, LLUMC-M Chief Financial Officer, LLUMC-M Hospital Cabinet, LLUMC-M Sr. VP/Administrator