Imperial Valley Healthcare District

Title: **Billing & Collection**	Policy No. ADM-00319
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Current Author: Cynthia Ramirez Veliz	Effective: 5/2024
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1.0 Purpose:

The Billing & Collection Policy (BCP), together in coordination with the Pioneers Memorial Hospital (PMH) Financial Assistance Policy (FAP), is intended to meet the requirements of applicable federal, state and local laws, including and without limitation, California Health and Safety Code Sections 127400 – 127446, as amended, and any regulations promulgated there under. The BCP applies to all patients and/or responsible parties who receive hospital medical care at PMH. 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.

2.0 Scope:

Patients who receive medically necessary services from PMH (as defined in California Welfare & Institutions Code §14059.5), including patients, patient families, physicians and hospital staff. This policy does not apply to physician services rendered at PMH.

3.0 Policy:

This policy defines the requirements and processes used by the PMH Patient Business Office when making arrangements with patients or individuals responsible for payment of a bill for services rendered. The BCP is designed to ensure appropriate billing and collection procedures are uniformly followed and reasonable efforts are being made 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 PMH for collection of debts arising from nonpayment for hospital medical care provided by PMH.

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

4.0 Procedure:

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

B. The PMH 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/responsible party accounts can occur.

C. Accurate information provides the basis for PMH 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 PMH prior to the completion of services

D. 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 PMH 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. Failure by the patient/guarantor to provide accurate information that is reasonable and necessary for the hospital to make a determination regarding the patient/guarantor's account, PMH may consider that failure in making its determination.

E. Medical care at PMH 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, PMH 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 PMH if the patient/responsible party 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 PMH Financial Assistance Program;
4. A written statement indicating how the patient/responsible party may obtain an application for the Medi-Cal, health plans available through Covered California, or other appropriate government coverage program;

5. If a patient/responsible party is uninsured, an application to the Medi-Cal, health plans available through Covered California, or other appropriate government assistance program will be provided. A PMH representative 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 full charity care and/or discount payment care under the PMH Financial Assistance Program. This statement shall include the name and telephone number of hospital personnel who can assist the patient/responsible party with information about and an application for the PMH Financial Assistance Program.
7. 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.

Hospital Bill Complaint Program

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.

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

G. All patients upon discharge shall receive an accessible format hard copy written notice containing the information below. The hospital shall maintain a contemporaneous record in accordance with the hospital's record retention policy, that the written notice was provided to the patient.

- Information on the availability of full and partial financial assistance through PMH
- How to apply using the FAA
- Where the patient may obtain a copy of the PMH financial assistance policy
- Basic financial assistance eligibility information

- Contact information for hospital personnel who can provide more information
- The hospital website for the list of shoppable services
- Information on the Health Consumer Alliance including the following statement:

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.

H. 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.

I. If the account may be payable by the patient's/guarantor's insurer, the initial claim will be forwarded directly to the designated insurer. PMH 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 PMH, any secondary or third payers will have claims filed by PMH on behalf of the patient/guarantor.

J. Once all insurance claims on an account have been resolved, any outstanding 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.

K. 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 PMH Financial Assistance Policy, or other policy discounts. Patients/guarantors with accounts in Self-pay status will be informed of these options by PMH registration and billing staff, and patients should contact a Patient Business Office representative to obtain assistance with qualifying for one or more of these options.

L. 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 discount payment, all deposits paid which exceed the patient 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/responsible party is received by the hospital. Interest amounts shall accrue at Ten Percent (10%) per annum. However, a hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00). The hospital shall refund the patient within 30 days. The hospital may reimburse the patient, but is not required to do so, if the hospital or the department determines that a patient qualified for financial assistance at the time the patient was first billed and either of the following has occurred:

(1) It has been five years or more since the last payment to the hospital, hospital assignee, or debt buyer.

(2) The patient debt was sold to a debt buyer in accordance with state law in effect at the time the debt was sold, if sold before January 1, 2022.

M. Self-pay accounts may be subject to a credit history review. PMH will use a reputable, nationally-based credit reporting system for the purposes of obtaining the patient/responsible party's historical credit experience.

N. 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 PMH.

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

P. 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 Director of the Patient Business Office or his/her designee shall implement procedures for compliance with the Charity Care Policy. Accounts may only be advanced for collections that are 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 PMH of any insurance coverage that may apply to the account; 3) information about government financial assistance including a Medi-Cal or county program application; 4) information about the PMH financial assistance program, hospital financial counselor contacts and a program application; 5) local consumer assistance center contact information including the Health Consumer Alliance at 888-804-3536 or go to healthconsumer.org for more information; 6) and the HCAI Hospital Bill Complaint Program.

Q. Prior to debt collection by the hospital or its collection agencies, or the sale of any debt for collection purposes, the PMH or its agents must comply with all of the following: 1) notice to the patient including the date of service; 2) who will be collecting the debt; 3) how to obtain an itemized bill for the services received; 4) the name of any insurance plan for the patient, or a statement that PMH does not have any insurance coverage information; 5) a PMH financial assistance application, along with documentation of the date a financial assistance application was provided to the patient and/or when a financial assistance determination was noticed to the patient; 6) local consumer assistance center contact information, including the Health Consumer Alliance at 888-

804-3536 or go to healthconsumer.org for more information; and the HCAI Hospital Bill Complaint Program.

R. Accounts may be advanced to collection status by PMH after 180 days according to the following schedule:

1. PMH or its Authorized Vendors will provide the patient/guarantor with five (5) billing statements via mail including notice that financial assistance may be available. PMH will also attempt to contact each patient/guarantor by telephone at least once during which notice of the PMH FAP will be offered to the patient/guarantor.
2. Any or all account balances, due from the patient/guarantor, where no payment has been received, and the patient/guarantor has not communicated with PMH within 60 days of initial billing, may be forwarded to collection status when:
    i. a minimum of one bill showing charge details and four cycle statements have been sent to the patient/guarantor;
    ii. at least one telephone contact attempt has been made and documented; and

iii. notice is provided to the patient/guarantor that payments have not been made in a timely manner and the account will be subject to collection 30 days from the notice date.

S. After 30 days or anytime when an account otherwise becomes past due and subject to internal or external collection, PMH will provide every patient/responsible party 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 which enforces the federal act, Contact by telephone at 1-877-FTC-HELP (382-4357) or online at www.ftc.gov."**

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

T. PMH 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 PMH 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 PMH Patient Business Office if circumstances change and payment plan terms cannot be met.

U. Certain patients/guarantors who have qualified for PMH discounted partial financial assistance are eligible for a Qualified Payment Plan as described in the PMH Financial Assistance Policy. Qualified payment plans involve negotiation between the hospital and

patient/responsible party and may result in a payment plan term which exceeds twelve (12) months. Qualified payment plans may be arranged by contacting a PMH Patient Business Office representative. Qualified payment plans are free of any interest charges. Once a qualified payment plan has been approved by PMH, 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 PMH Patient Business Office if circumstances change and payment plan terms cannot be met. However, in the event of a payment plan default, PMH will make a reasonable attempt to contact the patient/guarantor by telephone and also give notice of the default in writing. Notices of plan default will be sent the patient at least sixty (60) days after the first missed bill and provide the patient at least thirty (30) days to make a payment before the extended payment plan becomes inoperative. The patient/guarantor shall have an opportunity to renegotiate the extended 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 extended 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 may become subject to collection.

Attachment A – Policy Template; ADM-00061

V. For all patient/guarantor accounts where there is no 3rd party insurer *and/or* whenever a patient/responsible party provides information that he or she may have High Medical Costs, the Patient Business Office representative will ensure that the patient/responsible party has been provided all elements of information as listed above in E., and paragraph G above. 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.

W. PMH will only utilize external collection agencies with which it has established written contractual agreements. Every collection agency performing services on behalf of PMH must agree to comply with the terms and conditions of such contracts as specified by PMH. All collection agencies contracted to provide services for, or on behalf of PMH, shall also agree to comply with the standards and practices defined in the collection agency agreement; including this Billing and Collection Policy, the PMH Financial Assistance Policy and all legal requirements including those specified in the California Health & Safety Code and regulations promulgated by HCAI.

X. In accordance with the PMH Financial Assistance Policy, a patient may submit an application for PMH financial assistance at any point during the revenue cycle. PMH may identify a patient/guarantor potentially eligible for financial assistance in accordance with the PMH FAP. In the event that a financial assistance application is received by PMH or any Collection Agency subsequent to initiation collection activity, PMH or its Collection Agency shall immediately suspend enforcement of collections. During the period of collection suspension, PMH shall make reasonable efforts to determine whether the patient/guarantor is eligible for financial assistance under the FAP. Patents/guarantors must make reasonable efforts to provide accurate information when completing the Financial Assistance Application. PMH at it sole discretion, but no sooner than thirty (30) days from the start of suspension of collection, may determine if the patient/guarantor has made reasonable efforts to cooperate with the PMH 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. PMH determines that the patient/guarantor is not eligible for financial assistance under the PMH financial assistance policy.

Y. If a patient/guarantor has filed an appeal for coverage of services, PMH will extend the 180 day limit on transferring account to a collection agency, or other collection activity 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;

Z. A hospital, any assignee of the hospital, or other owner of the patient debt, including a collection agency or debt buyer, shall not do either of the following:

(1) Report adverse information to a consumer credit reporting agency.

(2) Commence civil action against the patient for nonpayment before 180 days after initial billing.

5.0 (3) Information obtained from income tax returns, paystubs, or the monetary asset documentation collected for the discount payment or charity care eligibility

determinations cannot be used for the collection activities.**Attachment List:** Not Applicable

6.0 Summary of Revisions:

6.1 Revised Healthcare District to Hospital as well as PMHD to PMH.

6.2 Added discount payment to partial charity care.

6.3 Revised section L. interest amount owed.

6.4 Revised section Y, removed "reporting to a credit agency".

6.5 Revised section Z, (3).