

POLICY: Patient Billing and Collection Policy
EFFECTIVE DATE: 5-1-2014
REVISED DATE(S): 12-28-21, 1-1-24, 12-17-24, 8-22-25, 8-27-2025

Southern Mono Healthcare District d/b/a Mammoth Hospital (“MH” or “Hospital”) is committed to maintaining the highest level of excellence in Customer Service. We recognize patients usually seek medical services out of necessity. We also recognize that the costs associated with this care are generally not budgeted for in advance. In addition to having to adjust to the physical, emotional, and spiritual elements associated with an illness or injury, patients and their families must also face an unforeseen financial burden. MH is committed to providing a compassionate and caring approach in helping our patients resolve their financial obligations associated with the hospital services they receive.

MH developed this policy, together with the Financial Assistance Policy, consistent with the requirements related to hospital billing and collection activities including California’s Hospital Fair Billing Law codified at Health and Safety Code section 127400-127446, et seq. and the associated implementing regulations at California Code of Regulations section 96051-96051.37, et seq., California’s Rosenthal Fair Debt Collection Practices Act as applicable to hospitals codified at Civil Code section 1788, et seq., section 501(r)(6) of the federal Internal Revenue Code, and the federal Fair Debt Collection Practices Act, Regulation F codified at 12 C.F.R. part 1006. A copy of the published Patient Billing and Collection Policy, and all amended or revised Policies, shall be provided to the State of California Department of Health Care Access and Information or “HCAI” (f/k/a the Office of Statewide Health Planning and Development) in accordance with HCAI state filing procedures (See generally, Title 22 of the California Code of Regulations (CCR) section 96040-96051.37, et seq.).

I. Purpose

This policy establishes reasonable procedures regarding billing and collection of patient accounts in accordance with applicable federal and state laws. Billing and collections actions may be taken by MH or contracted external companies and law firms.

II. Scope / Applicability

This policy applies to all Hospital inpatient and outpatient services in which MH performs billing (in most cases it includes physician professional fees).

III. Policy

A. Billing Procedures

1. Notification of Availability of Financial Assistance and Financial Expectations

MH widely publicizes the availability of financial assistance and makes reasonable efforts to identify individuals who may be eligible. The eligibility criteria and application process are set forth in MH's Financial Assistance Policy.

Consistent with this Policy and the Financial Assistance Policy, MH will clearly communicate with patients regarding financial expectations as early in the appointment and billing process as possible.

- Patients are responsible for understanding their insurance coverage and for providing needed documentation to aid in the insurance collection process.
- Patients may be required to pay a pre-service deposit or estimated co-pays, co-insurance and deductibles prior to services (except in the Emergency Department and other emergent situations).
- Patients are generally responsible for paying self-pay balances, including any amounts not paid by insurance companies or applicable third party payers.

2. Payer (e.g., Insurance and Health Plan) Collections

MH will maintain and comply with policies and procedures to ensure the timely and accurate submission of claims to all known health plans or insurance payers ("Payer") clearly identified by the patient. If MH timely receives from the patient complete and accurate information about the Payer but does not timely submit a claim to the Payer and the Payer denies the claim based on that untimely filing, the patient will be responsible for only the amount that the patient would be liable to pay had the Payer paid the claim. However, if MH determines that it either timely filed the claims or was provided inaccurate or incomplete information, then the patient will be held responsible.

MH shall not refer any Payer bill to a third-party collection agency or attorney for collection activity while a claim for payment of the services is pending with a contracted payer. MH may refer a Payer bill to a third-party collection agency or attorney following an initial denial or untimely denial of the claim by a Payer.

MH will not refer any bill to a third-party collection agency or attorney for collection activity when a claim is denied by a third-party payer due to MH's error and such error results in the patient becoming liable for the debt when they would not otherwise be liable. MH reserves the right to substantiate that an error has been made and if MH determines that it has not made an error, then the patient may be held liable. Patients must sign an authorization allowing MH to bill the patient's health plan, insurance company or any other third party payer, and must cooperate with MH in a reasonable manner by providing requested information to facilitate proper billing to a patient's health plan or insurance company.

MH makes every reasonable attempt to collect from all known Payers, with whom MH has a contract and non-contracted payers for services provided to assist patients in resolving their bills.

3. Self-Pay Balance Resolution

MH will employ reasonable procedures in a fair and consistent manner to collect patient self-pay balances, maintaining confidentiality and patient dignity. Financial Assistance is available to those patients whose income will not allow full payment of services within a reasonable time.

Self-pay collection procedures and process flows are followed by MH and must fully comply with this Policy. MH and its affiliates have developed a process for patients to question or dispute bills, including a toll-free phone number patients may call and an address to which they may send written correspondence. The phone number and address shall be listed on all patient bills and collection notices sent by MH. MH will make reasonable attempts to return telephone calls made by patients to this number as promptly as possible, but in no event later than five business days after the call is received.

B. Extended Payment Plans

MH and its Collection Agencies shall offer uninsured patients and insured patients with a patient responsibility portion the option to enter into an agreement to pay their patient responsibility portion and any other amounts due over time.

MH may declare an extended payment plan no longer operative after the patient fails to make all consecutive payments during a 90-day period. Before declaring the extended payment plan inoperative, MH or its Collection Agencies will make a reasonable attempt to contact the patient by the last known telephone number and provide notice in writing with the last known address to notify the patient that the extended payment plan may become inoperative and provide an opportunity to renegotiate. MH or the Collection Agency acting on MH's behalf will attempt to renegotiate the extended payment plan if requested by the patient.

After an extended payment plan is declared inoperative and over 180 days have passed since the initial billing of the patient, MH or its Collection Agencies may commence the Collection Practices described in Section C below).

C. Collection Practices

In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Billing and Collections Policy, MH's Collection Agencies may engage in further collection activities on MH's behalf. MH does not sell debt to its Collection Agencies. MH and its Collection Agencies shall not pursue collections from a patient who is attempting to qualify for Financial Assistance under Hospital's Financial Assistance Policy and is attempting in good faith to settle an outstanding bill.

1. Collection Agencies Reasonable Efforts to Identify Patients Eligible for Financial Assistance

Before engaging a Collection Agency to obtain payment, MH shall send the patient notice with a notice the following information:

- The date(s) of service of the bill that is being assigned to collections;
- The name of the entity the bill is being assigned;
- A statement informing the patient how to obtain an itemized hospital bill from MH;
- 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;
- A plain language summary and application for the MH's Financial Assistance Program;
- The date(s) the patient was originally sent a notice about applying for financial assistance, the date(s) the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made.

MH will further make reasonable efforts to orally notify individuals about the Mammoth Hospital's financial assistance policy.

2. Notification Period

MH will not send accounts to a Collection Agency for a period of 180 days after the date of the initial billing statement for the applicable medically necessary or emergency medical care. Where there is a pending appeal (as hereinafter defined) regarding coverage of the services and the patient makes a reasonable effort to communicate with the hospital about the progress of any pending appeal, this period will be extended until a final determination of that appeal is made. A "pending appeal" includes a grievance against a contracting health care service plan or against an insurer, an independent medical review, a Medi-Cal claim review fair hearing, or an appeal regarding Medicare coverage consistent with federal law and regulations.

If a patient submits a complete financial assistance application after the account has been referred to a collection agency, MH and its Collection Agencies will suspend collection activity and make an eligibility determination before resuming applicable collection activity. Once a determination on eligibility for financial assistance has been made, a "Financial Assistance Eligibility Determination Letter" will be sent to each applicant advising them of the MH decision. If a patient submits an incomplete application, MH will notify the patient about how to complete the application and give the patient a reasonable opportunity to do so.

3. Sending Accounts to Collection

After at least 180 days have passed since the initial billing statement was provided to the patient and either MH has found the patient ineligible for Financial Assistance or the patient has not responded to any attempt to bill or offer financial assistance, MH may place the patient's bill with a Collection Agency to collect outstanding balances under the authority of the of the Chief Financial Officer ("CFO") or his/her designee. When reviewing the account for referral to a Collection Agency, the CFO or his/her designee will confirm that:

- There is a reasonable basis to believe that the patient owes the debt.
- All known Payers have been properly billed such that any remaining debt is the financial responsibility of the patient. Where the patient has indicated an inability to pay the full amount of the debt in one payment, consideration of a reasonable payment plan is required provided that MH may require the patient to provide reasonable verification of the inability to pay the full amount of the debt in one payment.
- The patient has been given a reasonable opportunity to submit an application for Financial Assistance.

After the hospital has been notified that the patient has filed a complaint with HCAI, MH will not send the unpaid bill to any collection agency or other assignee unless that entity has agreed to comply with the Hospital Fair Pricing Act. This shall apply only to the bill(s) for which the patient has filed a complaint with HCAI.

4. No Extraordinary Collection Actions

MH and its agents, including Collection Agencies, do not engage in Extraordinary Collection Actions. Neither MH nor its agents will furnish any information related to a patient's debt to a consumer credit reporting agency, nor will either use wage garnishments or file a lien against a patient's primary residence as a means of collecting unpaid hospital bills.

D. Collection Agency

MH does not sell debt to Collection Agencies. MH may send accounts to Collection Agencies only after all reasonable collection and payment options have been exhausted. Collection Agencies may help resolve accounts for services that have been qualified and assigned to bad debt due to patients being uncooperative in making payments, not making appropriate payments, or being unwilling to provide reasonable financial and other data to support their request for financial assistance. MH and its Collection Agencies will not use any of the documentation collected during the Financial Assistance Application process (including paystubs and income tax returns) in their collection activities.

Collection Agency staff will uphold the confidentiality and individual dignity of each patient. All Collection Agencies will meet all HIPAA requirements for handling protected health information.

IV. **DEFINITIONS**

- **Charity Care:** Charity Care is free care provided when the patient is not expected to pay the patients payment obligation for items and services provided by MH. Charity care is based on financial need and is available to patients whose Family Incomes are at or below 200% of the most recent Federal Poverty Level.
- **Collection Agency:** a collection agency contracted by MH or other assignees not a subsidiary or affiliate of MH that is attempting to unpaid bills for provided services.
- **Discounted Care:** Discounted Care is a deduction from the payment obligations for items and services that is given to certain categories of patients, e.g., uninsured patients.
- **Extraordinary Collection Action (ECA):** Actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital's Financial Assistance Policy as further defined in 26 CFR § 1.501(r)-6(b).
- **Financial Assistance:** Financial Assistance is Charity Care or Discounted Care.

V. **Responsible Department**

Implementation, training, and monitoring compliance with this policy and procedure are the responsibilities of Revenue Cycle Management Director.

VI. **Renewal/Review**

This policy and procedure shall be reviewed at planned intervals and evaluated as necessary, but at least every two years to determine if it complies with current recommendations, guidelines, mandates, statutes, practices, and MH operations. If changes are required, the policy and procedure will be updated as needed.