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VALLEY PRESBYTERIAN HOSPITAL

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Department	Revenue Cycle - Patient Financial Services

Billing And Collection Policy

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PURPOSE:

To insure that accounts are billed and followed up in a timely manner.

POLICY:

This policy explains the Hospital's procedures related to collecting outstanding payments from patients and any insurer through which they have health insurance coverage. Some exceptions can be made, as risk management may need to hold, adjust or write off an account. Other exceptions may be granted by the Chief Financial Officer, VP of Finance, or Director of Revenue Cycle. All new staff members are trained on the process below.[1]

PROCEDURE:

I. Hospital Collection Efforts

A. The hospital shall make all reasonable efforts to obtain from the patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the hospital to a patient, including, but not limited to, private health insurance, Medicare, Medi-Cal, or other state-funded programs designed to provide health coverage.[2]

II. Insured Patients (including commercial insurers, Medicare, Medi-Cal, and all other payers)

A. After claims are submitted to insurers, whether electronically or in hard-copy form, the Patient Financial Services ("PFS") staff contacts the appropriate insurance

company by phone or using the insurer's website to determine when the remaining balance will be paid. If secondary or tertiary insurance is involved, a claim is submitted to that insurer after payment or denial is received from the primary insurer. **Once all insurers have issued payment and the account has been reviewed by a claims adjuster, any remaining balance is owed by the patient.**

III. Denials

A. If an insurer denies the Hospital's request for payment, the account is either resubmitted or appealed as appropriate based on the type of denial (medical necessity, no authorization, underpayment, etc.). If the claim continues to be denied by the insurer, the Hospital may decide it is necessary to write the claim off.

B. “Charity determination will be granted on an “all, partial, or nothing” basis. There is a category of patients who qualify for Medi-Cal but do not receive payment for their entire stay. Under the charity care policy definition, these patients are eligible for charity care write-offs. These patients are receiving the service, and they do not have the ability to pay for it. In addition, Medicare patients who have Medi-Cal coverage for their co-insurance/deductibles, for which Medi-Cal does not make payment, and Medicare does not ultimately provide bad debt reimbursement will also be included as charity. These indigent patients are receiving a service for which a portion of the resulting bill is not being reimbursed.”

IV. HRMG Communication

A. If the Hospital receives payment from an insurer and there is a remaining balance that is the responsibility of the patient ten (10) days after the Hospital receives payment from the insurer, the Hospital's Healthcare Resource Management Group (HRMG), an extension of the Hospital's Business Office, will contact the patient through a series of letters requesting payment on the account. The account remains with HRMG for 120 days, during which time they pursue payment from the patient. If after 120 days there is still an outstanding balance and no payment arrangement has been established, a "goodbye" letter is sent to the patient as per AB1020 effective 1/1/2022. The account is then referred to an outside Collection Agency. If a patient is attempting to qualify for eligibility under the Hospital's charity care or discount payment policy and is attempting in good faith to settle an outstanding bill with the hospital by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the hospital shall not send the unpaid bill to any collection agency or other assignee, unless it has agreed to comply with Cal. Health & Safety Sec. 127425, "Debt collection policy."[3]

V. Self-Pay (Uninsured) Patients

A. Three days after a patient's claim is coded and ready for billing, any self-pay accounts with outstanding balances are referred to the Healthcare Resource Management Group (HRMG), an extension of the Hospital's Business Office, who will contact the patient through a series of letters requesting payment on the account. The account remains with HRMG for 120 days, during which time they pursue payment from the patient. If after 120 days there is still an outstanding balance and no payment arrangement has been established, a "goodbye" letter is sent to the patient as per AB1020 effective 1/1/2022. The account is then referred to an outside Collection Agency.

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VI. Collection Notice[4]

A. Before commencing any collection activities, the Hospital or the Collection Agency will provide the patient with a clear and conspicuous notice outlining the patient's rights under the Rosenthal Fair Debt Collection Practices Act and the federal Fair Debt Collection Practices Act, and a statement that nonprofit counseling services may be available to the patient. The notice outlining the patient's rights shall be as follows:

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 www.ftc.gov." [5]

VII. Collection Agency Efforts

A. When the Hospital is not able to collect outstanding payments from a patient or an insurer through its own reasonable efforts, The Chief Financial Officer may authorize an outside Collections Agency to assist in obtaining outstanding payments.

VIII. Hospital - Collection Agency Requirements

A. The Hospital may only use a collection agency that has agreed in writing to adhere to the hospital's standards and scope of practices, including the California Hospital Fair Pricing Act.[6]

B. For any patient that is uninsured or has high medical costs, as discussed in the Hospital's Financial Assistance Policy, the Hospital, the Collections Agency or any other agent of the Hospital shall not report adverse information to a credit reporting agency or take any legal action against the patient for nonpayment.

C. The Hospital, the Collection Agency, or any other affiliate of the hospital cannot use wage garnishments or liens on any real property, such as a primary residence, as a means of collections.[8] This means that the Hospital, the Collection Agency, and other entities working with them cannot force you to give them your paycheck or threaten to sell your real property to satisfy your debt to the Hospital. Any income tax returns or paystubs collected by the Hospital for the discount payment or charity care eligibility determinations will not be used for collection activities.

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FOOTNOTES/REFERENCES:

1. ^ Cal H & S 127425(a).
2. ^ Cal H & S 127420(a).
3. ^ Cal H & S 127425.

4. ^ Cal H & S 127430(a)(1).
5. ^ Cal H & S 127430
6. ^ Cal H & S 127425(e).
7. ^ Cal H & S 127425(f)(1).
8. ^ Cal H & S 127425(h)(2).

All Revision Dates

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Approval Signatures

Step Description	Approver	Date
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Owner/Content Expert	Ivan Ferman: Manager-Patient Financial Services	5/1/2026