

**ANTELOPE VALLEY MEDICAL CENTER
PATIENT FINANCIAL SERVICES POLICY & PROCEDURE MANUAL**

POLICY NUMBER: PFS.IM.6

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SUBJECT: DEBT COLLECTION POLICY

REFERENCE(S): Patient Protection and Affordable Care Act
IRS Notice 2014-2 issued on December 30, 2013
Healthcare Financial Management Association Patient Financial Communications Best Practices (2014)
Healthcare Financial Management Association Patient Friendly Billing Guidelines
California AB 1020
California Health and Safety Code 127405(e)(1)(2)

PURPOSE This policy establishes Antelope Valley Medical Center's principles and guidelines for patient registration, patient billing and collection practices.

AFFECTED AREAS/DEPARTMENTS: Patient Access & Patient Financial Services

POLICY

1. All patients will be treated fairly, with dignity, compassion, and respect.
2. Antelope Valley Medical Center (the "Hospital") has developed a Financial Assistance Policy (FAP) that is consistent with its purpose statement, vision and values and government regulations. The policy is broadly communicated to reflect a commitment to provide financial assistance to patients who cannot pay for part or all of the care they receive.
3. The Hospital's FAP balances a patient's need for financial assistance with the Hospital's broader financial responsibilities.
4. Debt collection practices, both for the Hospital and its external collection agencies, reflect the Hospital's purpose statement, vision and values.
5. Financial assistance provided by the Hospital is not a substitute for personal responsibility. All patients are expected to contribute to the cost of their care, based upon their individual ability to pay, and applicable laws and regulations.
6. Financial assistance requests will be available for both uninsured and underinsured patients, including patients that do not have the financial ability to pay for their coinsurance and deductible portions after their insurance has paid.

AVMC Policies and Procedures may be viewed from Policy Manager accessible from the AVMC Portal

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7. Any financial information collected to determine eligibility for the Discounted Payment or the Charity Care Program, including recent pay stubs or income tax returns, will not be used for collections activities.
8. The Hospital will provide patients with “user friendly” billing statements and use best practices in patient financial communications.

PROCEDURES

1. POINT OF SERVICE COLLECTIONS AND PATIENT REGISTRATION

- A. Medical services will be provided to patients regardless of ability to pay, except for elective services, i.e., teeth extractions, voluntary sterilizations, and cosmetic surgery.
- B. The Hospital’s goal is to pre-register as many patients as possible. This affords the Hospital time in advance of providing the service, to verify insurance coverage, including patient deductible and copay amounts, and to discuss payment arrangements in advance with the patient.
- C. In circumstances where it is possible to estimate the charges for services during the complete registration process, the Hospital communicates this information to the patient and will attempt to collect advance payment of any deductible and/or copay amounts.
- D. At time of registration all patients are given a copy of our Plain Language Summary (Exhibit A) document that explains how to obtain additional information regarding patient financial assistance, as well as notification of their rights to receive a “Good Faith Estimation” (Exhibit B) for non-emergency self-pay related services.

2. BILLING FOLLOW-UP AND COLLECTION PRACTICES

- A. The follow-up and collection activities shall be performed in accordance with applicable laws and regulations. It is expected that account worklists and/or accounts receivable aging reports will be used by the Business Office staff to assist them in their follow-up and collection activities. Work queues/reports are periodically reviewed by the Director and Managers of

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Patient Financial Services to ensure timely follow-up and collection. All follow-up and collection activities shall be documented in the on-line notes section of the patient accounting software.

3. FOLLOW-UP AND COLLECTION ON SELF-PAY BALANCES

- A. The Hospital bills and collects on self-pay balances. Collection efforts may include telephone calls, as well as written communications to the patient. All patient statements will indicate that the Hospital offers financial assistance to its patients that meet established criteria, how to request an itemized bill, as well as the Hospital Bill Complaint program as required by laws and regulations.
- B. Patient statements will be sent out every twenty to thirty days until resolution or assignment to an outside agency. The final statement sent to the patient shall include the following:
 - 1. The date or dates of service of the bill that will be assigned to a collection agency.
 - 2. The name of the agency the bill is being assigned to.
 - 3. A statement informing the patient 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 Hospital's financial assistance.
 - 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.
- C. All unresolved self-pay balances that have completed the follow-up and collection cycle may be assigned to an outside collection agency. There are exceptions for patients who have an application pending for either government-sponsored coverage (e.g., Medicaid) or for the Hospital's financial assistance program, and/or they are reasonably cooperating with

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the Hospital in an effort to settle an outstanding bill. Under these exceptions, the Hospital will not send their bill to a collection agency.

- D. Upon a Hospital contracted collection agency's first attempt to collect a debt from a Hospital patient, the collection agency shall, among other regulatory requirements, include in the first written communication to the patient, a copy of the final statement provided by Hospital prior to referring the account to a collection agency, along with information about the Hospital's financial assistance program and a financial assistance application.
- E. The Hospital, or assignee of the Hospital, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment before 180 days after initial patient billing.
- F. Accounts meeting legal action requirements shall be considered a last resort after all reasonable collection efforts have been exhausted. Charges incurred related to any legal fees and court costs may be charged to the patient.

4. OTHER

- A. The Hospital shall obtain a written agreement from any service it contracts with to collect Hospital receivables that such service will adhere to all applicable Hospital policies and procedures with respect to financial assistance, billing and collection practices, and payment plans as well as all applicable federal, state, and local regulations.

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Exhibit A



Plain Language Summary Financial Assistance Policy

Antelope Valley Medical Center (AVMC) provides financial assistance to patients that may not have sufficient financial resources to pay for services.

Financial Assistance Eligibility Requirements

Financial assistance is available to uninsured or under-insured patients for emergency and medically necessary related care who meet eligibility and qualification requirements contained in our Patient Financial Assistance policy.

Eligibility for financial assistance may include family size and family income at or below 400% of the Federal Poverty Levels (FPL), using a sliding scale.

For information on poverty guidelines, visit the U.S. Department of Health & Human Services website at: <http://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

Guidelines for determining eligibility for financial assistance shall be applied consistently. In determining a patient's eligibility for financial assistance, AVMC's financial counselors will assist the patient (including referral to outside resources) in determining if he/she is eligible for government-sponsored programs, and to educate and assist them in understanding insurance coverages offered through the Covered California Health Insurance Exchange. You may also apply directly for these programs by accessing the below websites directly:

Medi-Cal: <http://www.dhcs.ca.gov/services/medi-cal/pages/applyformedi-cal.aspx>

Affordable Care Act: www.HealthCare.gov, to apply by phone call 1-800-318-2596

Find AVMC's policy: www.avmc.org/finforms

Application Process

Financial Assistance Applications may be requested:

1. In person at Patient Access Services, Main Admitting
2. By phone at (661) 949-5781
3. On our website: www.avmc.org/finforms
4. By mail to: Antelope Valley Medical Center
Attn: Business Office
1600 West Avenue J
Lancaster, CA 93534

The application specifies certain information that is required to be submitted with the application. This information may be independently verified by AVMC for completeness and accuracy. If you need assistance completing your application, please contact our Patient Financial Counselors at 661-949-5635.

There are organizations that will help patients understand the billing and payment process. For more information visit: <https://healthconsumer.org/>

Rev. 02/23

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Exhibit B

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost.

Under the law, health care providers need to give **patients who don’t have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider and any other provider you choose for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400.00 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call HHS at 877-696-6775.

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**RESPONSIBILITY FOR REVIEW AND MAINTENANCE OF THIS POLICY IS
ASSIGNED TO: Chief Financial Officer or designee.**

REVIEWED AND APPROVED:

Business Office Collection Manager

DATE: 3/28/25

Chief Financial Officer

DATE: 3/28/25

EFFECTIVE DATE: 09/26/2023

REVISED DATES: 3/28/2025

REVIEW DATES: See Policy Manager

CROSS REFERENCE(S):

Patient Financial Services Manual Policy entitled: PFS.RI.1 PATIENT FINANCIAL
ASSISTANCE PROGRAM

ATTACHMENT(S):