NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Billing and Collections		
Owner: Chief Executive Officer	Department: Administration	
Scope: Patient Access, Billing and Collections		
Date Last Modified: 01/11/2024	Last Review Date: 02/22/2024	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To establish clear and consistent guidelines for the collection of cash and cash equivalents that ensure compliance with federal, state, and District regulations and enhance patient satisfaction and efficiency.

POLICY:
In non-emergency situations, NIHD will collect the patient's co-payment, deductible, and share of costs based on insurance eligibility at or before the time of service. In emergencies, collection will occur after the patient has been stabilized and is no longer in distress from the medical emergency.

PROCEDURE:
General Rules:

NIHD is willing to establish payment plans for patients with outstanding debt. If a patient's account is overdue, NIHD will collaborate with debt collectors to recover the amount owed. Except for EMTALA rules, patients may be denied care if arrangements are not in place to settle outstanding debt and the patient does not follow the plan.

The Fair Debt Collection Practices Act (FDCPA) and the California Fair Debt Collection Practices Act (CFDCPA) - also known as the Rosenthal Fair Debt Collection Practices Act - protect consumers from abusive and deceptive debt collection practices. The FDCPA prohibits various aggressive debt collection strategies. NIHD will refrain from the following actions:

- Making repeated calls to induce annoyance or distress.
- Making any threats.
- Pretending to be lawyers, representatives from credit reporting companies, or government officials.
- Using abusive or obscene language.

Before assigning a bill to collections, NIHD will, at a minimum, provide the following information:

- The date or dates of the services provided in the bill.
- The name of the entity to which the bill is assigned or sold.
- A statement on how to obtain an itemized bill and an application for the hospital's financial assistance and charity care program.

Section 127430 - Written Notice Required Before Initiating Collection Activities Against a Patient
(a)Before starting any collection activities against a patient, the hospital, any designated assignee of the hospital, or any other owner of the patient's debt, including a collection agency, must provide the patient with a clear and prominent written notice. This notice must include the following:

(1) A plain language summary of the patient's rights under this article, the Rosenthal Fair Debt Collection Practices Act (Title 1.6C, commencing with Section 1788, of Part 4, Division 3 of the Civil Code), and the federal Fair Debt Collection Practices Act (Subchapter V, commencing with Section 1692, of Chapter 41, Title 15 of the United States Code). The summary must also state that the Federal Trade Commission enforces the federal act.

The summary shall be sufficient if it appears in substantially the following form: "**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**."

(2) A statement that nonprofit credit counseling services may be available in the area.

(b) The notice required by subdivision (a) shall also accompany any document indicating that the commencement of collection activities may occur.
(c) The requirements of this section shall apply to the entity engaged in the collection activities. If a hospital assigns or sells the debt to another entity, the obligations shall apply to the entity, including a collection agency engaged in the debt collection activity.

Insurance Billing:

- For all insured patients, Northern Inyo Healthcare District (NIHD) will bill the appropriate third-party payers based on information provided or verified by the patient or their guarantor in a timely manner. Due to the nature of insurance billing, insurance claims may take up to a year to be processed after the service date. Typically, bills are submitted five days after the service, excluding weekends and holidays. However, various factors may delay the billing process.
- If a payer denies or does not process a claim due to an error on NIHD's part, the organization will not charge the patient or their guarantor any amount exceeding what they would have been responsible for if the claim had been paid.
- If a claim is denied or not processed due to factors beyond NIHD's control, staff will follow up with the payer, the patient, or their guarantor as needed to help resolve the claim. NIHD will bill the patient or their guarantor if no resolution is reached after follow-up efforts.
- Once the insurance has adjudicated the bill, the appropriate entries will be made in the patient's record.
- If the account has a remaining balance, it will be classified as Early-out, Self-pay status.
- The general process for a patient’s bill is as follows:
    - Verification of benefits;
    - Collection of copayments, coinsurance, and deductibles before the appointment or procedure;
    - Billing the insurance company or companies can take up to a year, depending on the insurer's acceptance of the bill.
- After resolving the insurance claim, NIHD will bill any remaining balance, issue refunds for overpayments, or close the account according to contractual arrangements; concurrently, the account will move to self-pay, Early-out status, which typically takes up to three months from the insurance adjudication date.

- Patients will receive five monthly statements, telephonic communications, or other reasonable means of communication.
- Patients will receive a "Goodbye" letter with the sixth statement, which usually goes out 175 days after the first statement. This letter will inform the patient that their balance is being transferred to a debt collection agency.

Patient Billing: Early-out, Self-pay Practices

- Hospital care at NIHD is available to anyone needing necessary services.
- Patients or their guarantors may request an itemized statement at any time.
- For uninsured patients, NIHD will bill them or their guarantors, and they will receive a statement as part of the organization's normal billing process.
- NIHD will provide all uninsured patients a Notice of Available Financial Assistance and Charity Care Services.
- For insured patients, once third-party payers have processed claims, NIHD will bill the patient or guarantor for the remaining balance determined by their insurer or issue a refund for any overpayment.
- If a patient or guarantor disputes a charge, has questions or concerns, or requests documentation about the bill, NIHD will work to resolve the issue and notify the patient of the findings.
- NIHD may approve payment plan arrangements for patients or their guarantors who indicate difficulties paying their balance in a single payment.
- Generally, based on income, the balance may be financed for up to 24 months.
- NIHD will comply with all aspects of the No Surprise Act under **26 U.S. Code § 9816**, and under California Assembly Bill 72 (AB 72).

NIHD is not obligated to accept payment arrangements initiated by patients or their guarantors. Suppose a patient or their guarantor is unwilling to accept acceptable payment arrangements or has defaulted on an established payment plan; in that case, NIHD may refer the account to a collection agency, as outlined below.

Collections Practices

Northern Inyo Healthcare District may initiate collection activities to comply with applicable state and federal laws and follow the guidelines outlined in this Billing and Collections Policy. This includes possibly outsourcing collection efforts to external agencies to recover outstanding patient balances.

1. General collection activities may involve sending patient statements, making follow-up calls, and using letters, emails, messages, or any other authorized forms of communication.
2. Northern Inyo Healthcare District will strive to determine eligibility for financial assistance programs or charity for uninsured patients, underinsured, or facing high costs.
3. Patient balances may be referred to an outside collection agency for accounts over 180 days overdue if financing arrangements have not been made. The District will retain ownership of any debts referred to collection agencies. Patient accounts will only be referred for collection under the following conditions:
   a. There is a reasonable belief that the patient or their guarantor owes the debt.
   b. All third-party payers have been billed correctly, and any remaining debt is the patient's or their guarantor's responsibility. NIHD will not bill a patient or their guarantor for any amount that is the obligation of an insurance company to pay.
   c. NIHD will not refer accounts for collection while a claim on the account is still awaiting payment from the payer. However, despite efforts to resolve the issue, the District may classify certain claims as “denied” if they remain in “pending” status for an unreasonable amount of time.

d. NIHD will not refer accounts for collection if the claim was denied due to a District error. However, NIHD may still refer the patient's liability portion of such claims for collection if it remains unpaid.
e. NIHD will not refer accounts for collection if the patient or their guarantor has applied for financial assistance, charity care, or other District-sponsored programs and has not yet been notified of the decision. This applies as long as the patient or their guarantor has adhered to the timeline and provided the required information during the application process.

Financial Assistance
NIHD offers all patients or their guarantors the opportunity to apply for financial assistance or charity care for their accounts, payment plan options, and other relevant programs.

During collections, NIHD assists patients or their guarantors in accessing financial assistance and charity service programs.

Please refer to the Northern Inyo Healthcare District Financial Assistance and Charity Care Program for detailed procedures.

IRS Rule:
26 U.S. Code § 61 - Gross income defined
(a)General definition
Except as otherwise provided in this subtitle, gross income means all income from whatever source derived, including (but not limited to) the following items:
(11)Income from discharge of indebtedness;

NIHD will report the amount of discharge of indebtedness to the federal government when the billing and collections office determines that the likelihood of non-payment by the debtor is greater than the likelihood of payment. NIHD also reserves the right to negotiate payment options while ensuring compliance with federal law.

REFERENCES:
1. 26 U.S. Code § 61 - Gross income defined
2. Fair Debt Collection Practices Act (FDCPA)
3. California Fair Debt Collection Practices Act (CFDCPA) - Rosenthal Fair Debt Collection Practices Act
4. Medicare CMS Manual 15: The Provider Reimbursement Manual.

RECORD RETENTION AND DESTRUCTION:
Maintenance of records is for a minimum of fifteen (15) years.

CROSS-REFERENCE POLICIES AND PROCEDURES:
1. Financial Assistance and Charity Care Program
2. Bad Debt Policy
3. Pricing Transparency Policy

Supersedes: v.1 Billing and Collections

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Billing Write Off		
Owner: Chief Executive Officer	Department: Administration	
Scope: Revenue Cycle		
Date Last Modified: 01/05/2023	Last Review Date: 04/20/2023	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: Ensure compliance with coding and billing practices. Maintain and assure the integrity of the hospital's accounts receivable activities. Establish and define protocols and authority for billing adjustments and write-off activities.

POLICY: Only authorized personnel may carry out the specified write-offs in this policy. No write-off activities are permitted outside of those outlined here unless directed and approved by the Chief Financial Officer or the Chief Executive Officer.

PROCEDURE:

- Non-Billable Item

According to the hospital's payer contract, items marked as "non-billable" on a patient account will be flagged in the system. This allows the biller to write off these items as final claims on the patient's account. Non-covered items, as determined by the payer, will not be submitted to either the payer or the patient.

- Non-Covered Services - Payor Contract

Non-covered services performed outside of payors' contracts are not billed to patients if the District did not inform the patient of non-covered service prior to service. Charges are written off by billing staff using the Non-Covered Write-Off code.

- Denials - Payor Contract

The business office will write off unresolvable account denials for unforeseen non-covered services under the Insurance Contractual code. All accounts will be submitted to the Business Office Manager (BOM). For accounts with write-offs of $1,000 or more, approval from the Director of Revenue Cycle is required. For accounts exceeding $2,500, approval from the Chief Financial Officer (CFO) is necessary. Sufficient documentation must be provided to review and approve the write-off and then scanned into the patient's record.

- Billing Process Related Denials

Unresolvable denials related to billing process activities for covered services are written off by the business office using the Administrative Write-Off code. For accounts with write-offs of $1,000 or more, approval from the Director of Revenue Cycle is required. For accounts exceeding $2,500, approval from the Chief Financial Officer (CFO) is necessary. Sufficient documentation must be provided to review and approve the write-off and then scanned into the patient's record.

- Administrative Adjustment Write-Off (Discretionary)

When it is decided that certain reimbursable services should be written off due to unfavorable business outcomes or other discretionary reasons, the balances are adjusted using the administrative adjustment code. This discretion may be exercised out of concern for patient relations, billing or clerical errors, or oversights affecting reimbursement that are not addressed in other policies.

- Small Balance Write-Off

Small balance write-offs refer to patient account balances that are too minimal to warrant the time and expense of sending a bill to the patient. The threshold for these write-offs is $9.99 or less.

Monitor all write-off activities for any unusual trends, accuracy, and compliance with company policy.

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION:
Maintain records for fifteen (15) years.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Charge Reduction or Removal at Department Level

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Financial Assistance and Charity Care Policy		
Owner: Chief Executive Officer	Department: Administration	
Scope: District Wide		
Date Last Modified: 01/10/2024	Last Review Date: 12/21/2023	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/15/2017	

PURPOSE:

This document defines the eligibility parameters, the amount of aid possible, and the process of access to the Financial Assistance and Charity Care Program mandated by California **Health and Safety Code Section** (CA HSC) **127400-127446.**

DEFINITIONS:

CA HSC 127400: As used in this article, the following terms have the following meanings:

(a) "Allowance for financially qualified patient" refers to services rendered to a financially qualified patient. This allowance is applied after the District's charges are imposed on the patient due to the patient's determined financial inability to pay the charges.

(b) "Federal poverty level (FPL)" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

(c) "Financially qualified patient" means a patient who is both of the following:

(1) A patient who is a self-pay patient, as defined in subdivision (f), or a patient with high medical costs, as described in subdivision (g).

(2) A patient with a family income that does not exceed 400 percent of the federal poverty level.

(d) "Hospital" means a facility that is required to be licensed under subdivision (a), (b), or (f) of Section 1250, except a facility operated by the State Department of State Hospitals or the Department of Corrections and Rehabilitation. Northern Inyo Healthcare District includes a hospital and clinics called "the District."

(e) "Department" means the Department of Health Care Access and Information.

(f) "Self-pay patient" means a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital."

(g) “A patient with high medical costs” means a person whose family income does not exceed 400 percent of the federal poverty level, as defined in subdivision (b). For these purposes, “high medical costs” means any of the following:

(1) Annual out-of-pocket costs incurred by the individual at the Healthcare District that exceed the lesser of 10 percent of the patient’s current family income or family income in the prior 12 months.

(2) Annual out-of-pocket expenses that exceed 10 percent of the patient’s family income if the patient provides documentation of the patient’s medical expenses paid by the patient or the patient’s family in the prior 12 months.

(3) NIHD determined a lower level per the district’s Financial Assistance and Charity Care policy.

(h) “Patient’s family” means the following:

(1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21, whether living at home or not.

(2) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

(i) A "reasonable payment plan" refers to monthly payments that do not exceed 10 percent of a patient's family income for that month, excluding deductions for essential living expenses. "Essential living expenses" are defined for this purpose as costs associated with the following:

- Rent or mortgage payments and maintenance;
- Food and household supplies;
- Utilities and telephone bills;
- Clothing;
- Medical and dental expenses;
- Insurance;
- School or childcare expenses;
- Child or spousal support;
- Transportation and auto-related expenses, including insurance, fuel, and repairs;
- Installment payments;
- Laundry and cleaning;
- Other extraordinary costs.

This definition ensures that patient payment plans are manageable while accounting for their necessary living expenses.

POLICY:

Northern Inyo Healthcare District (NIHD) is committed to providing healthcare access to uninsured, underinsured, or those who may face high medical costs. This assistance is available for medically necessary services and care. NIHD’s Financial Assistance and Charity Care Program is eligible based on Federal Poverty Level (FPL) guidelines.

The Notice of Available Charity and Discount Services included in this policy will be updated annually following the Federal Poverty Level (FPL) release. This update will use 400 percent of the government’s poverty income level to determine eligibility for free, discounted, or financed care. Additionally, NIHD will provide financing arrangements to help ease the burden of healthcare costs. The following criteria will be used to determine the type and level of assistance provided:

1. The eligibility criteria will consider the gross income of the applicant, their family, or the entire household. This includes alimony, child support, financial contributions from an absent parent, and all other income from any source, along with household size.

2. Income from any source will be used to evaluate the applicant's level of responsibility. The following outlines the types and amounts of assistance available:
    a. When total income exceeds 100% of the FPL, NIHD will provide free care through the Financial Assistance and Charity Care application and approval process.
    b. When the total income is above 100% and below 200%, NIHD will provide a 50% discount and long-term financing through the Financial Assistance and Charity Care application and approval process.
    c. When the total income is above 200% and equal to or less than 250%, NIHD will offer a 40% discount and long-term financing through the Financial Assistance and Charity Care application and approval process.
    d. When the total income is above 250% and equal to or lower than 300%, NIHD will offer a 20% discount along with long-term financing through the Financial Assistance and Charity Care application and approval process.
    e. When the total income is above 300% and equal to or less than 350%, NIHD will provide a 15% discount and offer long-term financing through the Financial Assistance and Charity Care application and approval process.
    f. When the income is above 350% and at or below 400%, NIHD will provide a 10% discount and offer long-term financing through the Financial Assistance and Charity Care application and approval process.
    g. When total income exceeds 400%, NIHD will provide long-term financing through the Financial Assistance and Charity Care application process.
3. Verification of the patient's household income may include the following applicable documents:
    a. Paycheck stubs for the last three months;
    b. Unemployment payment stubs;
    c. Disability payment stubs;
    d. Bank statements for the last three months;
    e. A copy of the current or previous year's income tax return;
    f. A copy of the currently approved or denied letter from the local social service assistance program (Medi-Cal).
4. If the applicant has no source of income, we will inquire about how the patient is supported.
5. All other coverage resources will first be sought. This includes, but is not limited to, any available local social service assistance program such as Medi-Cal and CCS (California Children's Services); Medicare; insurance; employer-provided or offered health plan; Inyo County Medical Services Program (CMSP); other available third-party sources; and participation in the Affordable Care Act.
    a. Individuals without insurance will receive assistance in following the Affordable Care Act and participating in the "Open" Enrollment.
    b. Applicants are ineligible for assistance through their local department; therefore, Social Services Medicaid programs must be denied in writing.
    c. If an applicant qualifies for Medi-Cal or another state's Medicaid program with a Share of Cost, they are not eligible for the Financial Assistance and Charity Care Program to help fulfill Share of Cost responsibilities. Once the Share of Cost is met, the applicant's Medi-Cal will be accepted as payment for covered services.
    d. Failure to complete the application for local social service assistance programs may result in denial of the NIHD Financial Assistance and Charity Care Program.
6. To maintain eligibility, NIHD Financial Assistance and Charity Care recipients must submit a new application every twelve months. This includes applying for available local social service assistance programs.

7. If any information provided proves untrue, NIHD reserves the right to reevaluate the application and take whatever action becomes appropriate, up to disqualification and revocation of Financial Assistance and Charity Care.
8. Once the completed application and all supporting documents are received, efforts will begin to determine whether the patient qualifies for the NIHD Financial Assistance and Charity Care Program.
9. Conditional qualification can be applied when eligibility for other assistance programs is still undetermined.
10. Individuals who do not respond to notifications regarding charity or discount services, fail to reply to billing and collection efforts, and have their accounts assigned to bad debt or an external collection agency will not qualify for adjustments under NIHD's Financial Assistance and Charity Care program.
11. Financial assistance and charity care denials for patients based on their income may be reconsidered if their income changes after the initial determination, provided they supply additional information. However, subsequent approvals will not result in refunds for previous payments.
12. The effect of the eligibility determination will not be open-ended. Charity status may be reviewed during the covered period, not to exceed one year.
13. The initial billing statement for uninsured individuals will include the following documents from Northern Inyo Healthcare District:
    a. Request for Health Coverage Information;
    b. Notice of Other Coverage Programs;
    c. Financial Assistance and Charity Care Services;
    d. These documents are part of this policy.
14. Ensure that information regarding NIHD's Financial Assistance, Charity Care, and Discount Payment Program is prominently displayed in all patient care areas, including waiting rooms, reception areas, and the Billing Information Office. This requirement applies to the Rural Health Clinic and all Northern Inyo Associates offices.
15. Applications for the NIHD Financial Assistance and Charity Care Services will be available through the Northern Inyo Healthcare District's Administration, the Social Services Department, and the Credit and Billing Information Office.
    a. The application must include the applicant's complete name, address, telephone number, social security number, employer, family size, income, services rendered or requested, service date, applicant's signature, and space for eligibility determination.
16. The Credit & Billing Information Staff will process complete applications within ten business days.
17. The Credit and Billing team will send the applicant a final determination notice by US mail.
18. https://healthconsumer.org for additional assistance.

REFERENCE:

1. California Health and Safety Code Section 127400-127446.
2. CA AB 1020

RECORD RETENTION AND DESTRUCTION:

Maintain all patient accounting files for fifteen (15) years.

CROSS-REFERENCE POLICIES AND PROCEDURES:

1. Billing and Collections
2. Price Transparency
3. Credit Balance Refund Processing
4. Prompt Pay Discounts
5. InQuiseek - #600 Financial Policies

Supersedes: v.2 Charity Care Program

REQUEST FOR HEALTH COVERAGE INFORMATION

NOTICE OF OTHER COVERAGE PROGRAMS

OF AVAILABLE FINANCIAL ASSISTANCE AND CHARITY CARE

When you presented for your recent services, it appeared that you may not have health insurance or other coverage. If this is incorrect, please get in touch with our Credit and Billing Information office at (760) 873-2097 as soon as possible to provide us with your coverage information.

You may be eligible for Medicare, MediCal, CMSP, or CCS if you do not have health or other coverage.

Contact our Credit and Billing Information office at (760) 873-2190 or your local Social Services office for a medical application.

You may obtain information from the Social Security Office regarding Medicare benefits or your local county Health Department regarding CMSP and CCS benefits.

The Northern Inyo Healthcare District's policy is to provide reasonable amounts of care without or at a low charge to the uninsured, underinsured, or those with high medical costs. Individuals within the annual income requirements established below may be eligible to receive free or discounted medical care based on income level and family size.

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in the family/household	**Poverty guideline**
1	$14,580
2	$19,720
3	$24,860

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in the family/household	**Poverty guideline**
4	$30,000
5	$35,140
6	$40,280
7	$45,420
8	$50,560
For families/households with more than eight persons, add $5,140 for each additional person.	

If you believe you may be eligible or would like more information or an application, contact the Credit and Billing Information Office, Monday through Friday, 8:30 a.m. to 4:30 p.m. Telephone: (760) 873-2097.