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Owner	Melinda Rosas Manager Revenue Cycle SBO
Area	Patient Financial Services / Patient Access Services
Applicability	SCOR, SCV, SGH, SMB, SMC, SMH, SMV
References	Accounts Receivable, Person-Centered-Care, Planetree, Policy

Billing, Collections and Bad Debt Review, 15801

I. PURPOSE:

To provide clear directives for Sharp HealthCare hospital facilities to conduct billing and collections functions in a manner that complies with applicable laws. Establish the guidelines for collection of monies owed for visits and the identification of bad debt visit referral.

II. POLICY:

It is the policy of Sharp HealthCare to bill patients and applicable third-party payers accurately, timely and consistent with applicable laws and regulations, including, without limitation, California Health and Safety Code section 127400 et seq. and regulations issued by the United States Department of the Treasury under section 501(r) of the Internal Revenue Code.

III. SCOPE:

This policy applies to all Sharp HealthCare Hospitals and Hospital Services. This policy also applies to any collection agency working on behalf of a Hospital. Unless otherwise specified, this policy does not apply to physicians or other medical providers, including emergency room physicians, anesthesiologists, radiologists, hospitalists, pathologists, etc., whose services are not included in a Hospital's bill. This policy does not create an obligation for the Hospital to pay for such physicians' or other medical providers services.

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IV. DEFINITIONS:

A. **FINANCIAL ASSISTANCE POLICY:** Patient Financial Assistance Including Discounted Payments, and Charity Care, 15602.99. This describes Sharp HealthCare's Financial Assistance policy – including the criteria patients must meet in order to be eligible for financial assistance as well as the process by which patients may apply for Financial Assistance (Charity Care).

B. **FINANCIAL ASSISTANCE:** Financial Assistance or Charity Care refers to free care of full assistance (100% discount) provided to qualifying patients relieving them and their guarantor of the entire financial obligation for medical services. Charity Care does not decease the amount that a third-party may be required to pay for eligible services provided to the patient.

C. **DISCOUNTED PAYMENT AMOUNT FOLLOWING AMOUNT GENERALLY BILLED (AGB):** Medical care that is reduced but not entirely free. This reduced amount signifies the amount generally billed, as outlined by the Internal Revenue Service (IRS) requirements. Sharp HealthCare employs the prospective method for determining AGB and estimates the amount that would be paid by a Medicare beneficiary.

D. **HOSPITAL OR SHARP HEALTHCARE HOSPITALS:** Refers to (a) all licensed hospital facilities operated by Sharp HealthCare and (b) all hospitals where Sharp HealthCare and/or an Affiliated Entity hold a direct or indirect voting control or equity interest exceeding fifty percent (50%), as well as all substantially-related entities [as defined in 26 C.F.R. section 1.501(r)-1(b)(28)], to the extent that these hospitals and substantially-related entities provide emergency services.

E. **HOSPITAL SERVICES:** Refers to all services that a hospital is authorized to offer, encompassing both emergency and other medically necessary care, but excluding complex or specialized services.

F. **GUARANTOR:** If not the patient, a guarantor can be a person that is responsible for the patients healthcare services, usually a parent or legal guardian.

G. **PATIENT FAMILY:**

- For patients 18 years of age and older, the definition of “patient’s family” includes dependent children of any age if those children are disabled.
- For patients (1) under 18 years of age or (2) who are 18 to 20 years of age and are a dependent child, the definition of “patient’s family” includes other dependent children of the patient’s parents or caretaker relatives if those other children are disabled.

H. **BILLED CHARGES:** "Billed Charges" are the undiscounted amounts that a Hospital customarily bills for items and services.

I. **PATIENT RESPONSIBILITY**: The remaining balance that the patient is responsible for, regardless of insurance status, after applicable payments,

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adjustments, or assistance have been applied for the services rendered.

J. **THIRD-PARTY PAYER:** Means a non-government third party payer that providers coverage for healthcare services to a Patient.

K. **COLLECTION AGENCY:** A "Collection Agency" is any entity engaged by a Hospital to pursue or collect payment from patients upon assignment.

L. **UNINSURED PATIENT:** An "Uninsured Patient" is a patient who has no third-party source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored healthcare benefit programs, or third-party liability, and includes a patient whose benefits under all potential sources of payment have been exhausted prior to an admission.

M. **SELF-PAY PATIENT:** An insured patient who will not submit a claim to their insurance for covered and/or non-covered services:

    1. Uninsured (or self-pay) individual means:

        a. An individual who does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal healthcare program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code; or

        b. An individual who has benefits for such item or service under a group health plan, or individual or group health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code but who does not seek to have a claim for such item or service submitted to such plan or coverage. These services would not be eligible for submission to the payer by the patient to seek reimbursement.

N. **INSURED PATIENT:** A patient who has insurance coverage through a third-party payer, such as a health insurer, healthcare service plan, Medicare, or Medicaid.

O. **EXTRAORDINARY COLLECTION ACTION:** Except as otherwise set forth below, an Extraordinary Collection Action (ECA) is any of the following:

    1. Assign an individual's Hospital debt to a third party, including, without limitation, to a Collection Agency.

    2. Deferring or denying medically necessary care, or requiring payment before providing such care, due to unpaid bills for previous care covered under the Hospital's Financial Assistance Policy is considered an ECA. If a Hospital demands payment before providing necessary care to someone with unpaid bills, it is presumed to be due to nonpayment unless the Hospital can prove otherwise.

    3. Actions that require a legal or judicial process that are not pursued by

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Sharp HealthCare:

a. Place a lien on an individual's property (other than a lien described below)
b. Obtaining an order for examination.
c. Attaching or seizing an individual's bank account or any other personal property;
d. Commencing a civil action against an individual;
e. Causing an individual's arrest;
f. Causing an individual to be subject to a writ of body attachment; and
g. Garnishing an individual's wages.

ECA do not include the assertion of or collection under, a lien asserted under Civil section 3040 or 3045. Further, filing a claim in a bankruptcy proceeding is not an Extraordinary Collection Action.

1. ECA does not include:
    a. If a hospital assigns an individual's debt for care to another party, and there is a legally binding agreement prohibiting the assignee from engaging in extraordinary collection actions (ECAs) to obtain payment, the assignment must be shortened.
        i. Sharp HealthCare does not sell accounts to bad debt agency. Sharp HealthCare may assign accounts to bad debt agency.
        ii. The debt is returnable to or recallable by the Hospital upon a determination by the Hospital or the purchaser that the individual is eligible for Hospital's Financial Assistance Policy; and
        iii. Delay or denial of medically necessary care based on the existence of an outstanding balance for proper service(s); or
    b. Any lien that the Hospital is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the Hospital provided care, including the assertion of or collection under a lien asserted under Civil Code sections 3040 or 3045.

P. **STATEMENT LEVELS:** Means the number of statements sent to a patient. The first patient statement is mailed once the visit is final billed and patient responsibility is determined; subsequent statements are mailed approximately

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every 28 days for a total of 4 billing cycles. Once a payment plan has been established for reoccurring payment by credit card, statements are no longer sent. The Good Bye Letter will be mailed to any guarantor owing hospital charges after the expiration of the level four statement and 10-day prior to assignment of bad debt.

Q. **CONTACT:** Direct connect or automated dialing system outbound calling to patients in attempt to offer payment arrangements, assistance with securing government source of funds or offering financial assistance. Hospital shall strictly adhere to applicable provisions of the Rosenthal Act, Fair Debt Collection Practices Act (FDCPA), Health Insurance Portability and Accountability Act (HIPAA), and Telephone Communication Practices Act (TCA).

R. **BAD DEBT:** The amounts due and owing to a Hospital for all goods and Hospital Services rendered to a patient by a Hospital where:

1. The guarantor/patient has the financial capability to pay for the goods or Hospital Services and (a) indicates that he or she does not intend to pay or (b) fails to come to an acceptable payment agreement.
2. Hospital is unable to contact the guarantor/patient due to a lack of information on the visit, mail return, or no reply from contact attempts. Amounts due and owing from patients/guarantors with no information or mail return may be assigned bad debt at any time. Amounts due and owing from patients/guarantors from whom no reply is received by Hospital may proceed through standard dunning cycles and will be considered for placement of bad debt.

Bad debts are transferred off the Sharp HealthCare Accounts Receivable balance and are assigned to a collection agency for further follow-up. The collection agency is not to enforce any ECA's or report any "derogatory/adverse action to any credit bureaus.

S. **PATIENT PROVIDER DISPUTE RESOLUTION:** A Patient-Provider Dispute Resolution (PPDR) process is available for uninsured (or self-pay) consumers who get a bill from a provider that is at least $400 more than the expected charges on their good faith estimate. Under the PPDR process, an uninsured (or self-pay) consumer, or their authorized representative, may initiate the dispute process. This process brings in an independent third-party called a dispute resolution entity to determine the appropriate amount the consumer must pay.

T. **MEDICAL DEBT:** "Medical debt" refers to a debt owed by a consumer to a provider of medical services, products, or devices, or to their agent or assignee. It includes medical bills that are current or have been paid.

- “Medical service, product, or device” does not include cosmetic surgery, but does include, without limitation, all of the following:
    - Any service, drug, medication, product, or device sold, offered, or provided to a patient by licensed health care facilities or

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providers.

- Initial or subsequent reconstructive surgeries, and follow-up care deemed necessary by the attending physician and surgeon.
- Initial or subsequent prosthetic devices, and follow-up care deemed necessary by the attending physician and surgeon.
- A mastectomy.

U. **Good Faith Estimate (GFE):** A document that provides an estimated cost for medical services to uninsured or self-pay patients before they receive care.

V. PROCEDURES:

There will be reasonable attempt(s) to contact the patient/guarantor for debt resolution. Bad debt shall be transferred to a collection agency for collection only after several attempts to contact the patient/ guarantor via statement or phone have been put forth or no contact information is available, or an agreement has not been established. The primary purpose of a collection contact is to advise the patient/guarantor of the outstanding debt and to obtain payment. Amounts due from patients/ guarantors who refuse to pay, or with no information or mail return may be assigned bad debt at any time.

1. **Billing Third-Party Payers**
   Obtaining Coverage Information: Hospitals shall make reasonable efforts to obtain information from patients about whether private or public health insurance or sponsorship may fully or partially cover the services rendered by the Hospital to the patient.
2. **Billing Third-Party Payers**: Hospitals shall diligently pursue all amounts due from third-party payers, including but not limited to contracted and non-contracted payers, indemnity payers, liability and auto insurers, and government program payers that may be financially responsible for a patient's care. Sharp HealthCare will bill all applicable third-party payers based on information provided by or verified by the patient or their representative in a timely manner.

A. **Billing Patients**: Sharp HealthCare will bill the patient for services rendered or shall grant authority to the collection agency to pursue collections on behalf of Sharp Hospitals.

1. **Billing Insured Patients**: Hospitals shall bill insured patient or secondary insurance for the patient responsibility amount as computed by the Explanation of Benefits (EOB).
2. **Billing Uninsured Patients**: Hospitals shall promptly bill Uninsured Patients for items and services provided by Hospital, using Hospital's Billed Charges less the Standard Uninsured Discount.
    a. For scheduled services, payment is due prior to the delivery of services.
        i. Good Faith Estimates for anticipated services are

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available and delivered within 3 business days from scheduling when the service is scheduled more than 10 days in advance.

a. For services scheduled within 3 days from the date of service the good faith estimate will be delivered within one business day.

ii. In the event the actual billed charges exceed the good faith estimate by $400 or more, the patient has the right to initiate the patient-provider dispute resolution process.

b. Standard Uninsured Discount: 25% reduction of Billed Charges for Inpatient Services and Outpatient Services. ****The Uninsured Patient Discount does not apply to patients who receive services that are already discounted (i.e. package discounts or cosmetic services). Case rate and package rate pricing should not result in an expected payment that is less than what the Hospital would expect had the Uninsured Patient Discount been applied to Billed Charges for the services.**

3. **Financial Assistance Information**: All patient bills must include the Notice of Rights, found on the back page of the billing statement. This notice provides a summary of the Financial Assistance available to eligible patients. Each Hospital is required to make reasonable efforts to assess a patient's eligibility for Financial Assistance in accordance with its Financial Assistance Policy. A Hospital is considered to have made reasonable efforts to determine an individual's eligibility for Financial Assistance if any of the following conditions are met:

a. If an individual is deemed eligible based on information other than what they have provided, or from a previous eligibility determination, and they are presumptively determined to qualify for less than the maximum assistance available under the Financial Assistance Policy, the Hospital will:

i. Notify the patient about the basis for their presumptive eligibility determination under the Financial Assistance Policy and informed on how to apply for more generous assistance available under the policy.

b. If the individual submits a complete Financial Assistance application seeking more generous assistance during the application period, determine whether the individual is eligible for a more generous discount and satisfies the

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requirements of the Hospital's Financial Assistance Policy and Section 3(B)(iii), below, with respect to the complete Financial Assistance application; or

c. Inform the individual about the Financial Assistance Policy prior to starting any extraordinary collection actions (ECAs) to obtain payment for the care and abstains from initiating such ECAs (except for those described in Section 3 of the ECA definition) for a minimum of 180 days from the date the Hospital issues the first post-discharge billing statement for the care.

d. In the event that an individual submits an incomplete Financial Assistance application during the application/appeal period, the individual is informed about how to complete the application. The individual is given a reasonable opportunity to do so by halting any extraordinary collection actions (ECAs) to obtain payment for the care. Additionally, the individual receives a written notice detailing the additional information and/or documentation required under the Financial Assistance Policy or application. This notice includes the telephone number and physical location of the Hospital office or department that can provide further information about the Financial Assistance Policy.

4. **Detail Bill**: All patients may request an itemized statement (IZ) for their account at any time, excluding pricing for Flat Rate or Package Pricing.

5. **Disputes:** A patient may dispute an item or charge on his or her bill. Patients may initiate a dispute in writing or over the phone with a customer service agent . If a patient requests documentation regarding the bill, staff members will use reasonable efforts to provide the requested documentation within 10-days.

   Hospitals will contest account and hold from:

   a. Self-Pay/Cash Pay patient disputes Sharp will hold/pull back from collections

   b. Discontinue any collection activity pending dispute

   c. Review the timeliness requirements from PPDR

B. **Good Faith Estimates (GFE):**

1. Notice of Right to Request GFE. Uninsured and Self-Pay Patients must be advised both orally and in writing that they have the right to request a GFE before they schedule an item or service, and if not requested, a GFE of expected charges must be provided upon scheduling.

2. Content of the GFE. The GFE must reflect the expected charges, including

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any expected discounts or other relevant adjustments that the provider or facility expects to apply to an Uninsured or Self-Pay Patient's actual Billed Charges.

3. Delivery of GFE. Pursuant to the Uninsured or Self-Pay Patient's requested method of delivery, the GFE must be provided either on paper or electronically (for example, electronic transmission of the GFE through provider's patient portal or electronic mail). If provided electronically it must be provided in a manner that allows the GFE to be saved and printed.
4. Timing of Delivery of GFE
    a. If an Uninsured or Self-Pay Patient requests the GFE prior to scheduling a service, the GFE must be provided no later than three (3) business days after the request.
    b. If a service is scheduled at least three (3) days, but less than ten (10) days in advance, the GFE must be provided no later than one (1) business day after the date of scheduling.
    c. If a service is scheduled at least ten (10) days in advance, the GFE must be provided no later than three (3) business days after the date of scheduling.

C. **Uninsured/Self-Pay Dispute Resolution Process:**

1. An Uninsured or Self-Pay Patient has the right to initiate the patient-provider dispute resolution process if the actual Billed Charges are at least $400 more than the total amount of expected charges listed in the GFE.
2. Within one hundred twenty (120) calendar days of receiving the initial bill containing charges at least $400 more than the GFE, an Uninsured or Self Pay Patient may initiate the patient-provider dispute resolution process by submitting a notification on the Federal IDR portal or on paper to the Secretary of HHS (U.S. Department of Health and Human Services).

D. **Collection Practices:** General Collection Practices: Subject to this policy, Hospitals may employ reasonable collection efforts to obtain payment from patients.

1. General collection activities may include sending patient statements, making phone calls, and using automated calls according to the Hospital's conditions of admission.
2. No collection activities will take place during Financial Assistance Application Process: Hospital and Collection Agencies shall not pursue collection from a patient who has submitted an application for Financial Assistance and shall not engage in ECAs against a patient or guarantor to obtain payment for care before the Hospital has made reasonable efforts

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to determine whether the patient is eligible for assistance under the Hospital's Financial Assistance Policy.

3. Prohibition on use of Information from Financial Assistance Application: Hospitals and Collection Agencies may not use in collection activities any information obtained from a patient during the application process for Financial Assistance. Nothing in this section prohibits the use of information obtained by Hospital or Collection Agency independently of the eligibility process for Financial Assistance.
4. Payment Plans:
    a. Hospitals may enter into payment plans with patients who indicate they are unable to pay a Patient Responsibility amount in a single installment.
    b. Terms of Payment Plans: All payment plans made directly with the Hospital shall be interest-free. Patients shall have the opportunity to negotiate the terms of the payment plan. If a Hospital and patient are unable to agree on the terms of the payment plan, the Hospital shall extend a payment plan option under which the patient may make a minimum monthly payment. Accounts subject to a payment plan shall not be subject to ECAs provided the patient remains in compliance with the terms of the payment plan.
    c. Declaring Payment Plan Inoperative: Prior to the extended payment plan being declared inoperative, the Hospital or Collection Agency shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. An extended payment plan may be declared no longer operative if the following apply.
        i. The 90-day period specified in Health and Safety Code section 127425 (i) begins on the due date of the first billing statement that the patient misses.
        ii. Notices mandated by Health and Safety Code section 127425(i) must be sent at least 60 calendar days after the first missed bill, allowing the patient at least 30 calendar days to make a payment before the extended payment plan becomes inoperative.
        iii. When a hospital declares an extended payment plan inoperative under Health and Safety Code section 127425(i), the patient's financial responsibility will not surpass the previously determined discounted amount according to Health and Safety Code section 127405(d).

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Additionally, the patient will receive credit for any payments already made under the extended payment plan.

5. Collection Agencies: Hospitals may opt to refer patient accounts to a Collection Agency, subject to the following conditions:
    a. The Collection Agency must have a written agreement with the Hospital.
    b. Hospital's written agreement with the Collection Agency must provide that the Collection Agency's performance of its functions shall adhere to Sharp HealthCare's mission, vision, core values, the terms of the Financial Assistance Policy 15602.99, this Billing, Collections and Bad Debt Review Policy 15801, and the Hospital Fair Pricing Act, as well as Health and Safety Code sections 127400 through 127446.
    c. The Collection Agency must agree that it will not engage in any Extraordinary Collection Actions to collect a patient debt.
    d. Hospital must maintain ownership of the debt (i.e. the debt is not "sold" to the Collection Agency).

        The Collection Agency must have processes in place to identify patients who may qualify for Financial Assistance, communicate the availability and details of the Financial Assistance Policy to these patients, and refer patients who are seeking Financial Assistance back to the Hospital's Patient Financial Services Department, 858-499-2400, or to Sharp.com/billing/Financial-Assistance. The Collection Agency shall not seek any payment from a patient who has submitted an application for Financial Assistance and shall suspend ECAs to obtain payment until Financial Assistance Policy eligibility is resolved. If it is determined the individual is eligible for Financial Assistance, the Collection Agency shall (i) adhere to procedures specified in the written agreement with the Hospital that ensure the individual does not pay, and has no obligation to pay, the Collection Agency and the Hospital together more than he or she is required to pay for the care as a Financial Assistance-eligible individual; (ii) if applicable, hospitals will provide Sharp HealthCare with the authority to refer accounts to a Collection Agency to take all reasonably available measures to reverse any ECA

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(other than the sale of a debt or an ECA described in Section 3 of the definition of ECA) taken against the individual; and (iii) if the Collection Agency refers or sells the debt to another party during the application period, the Collection Agency must obtain a written agreement from that other party including all of the elements described in this section.

e. All third-party payers must have been properly billed. A Collection Agency when notified, shall not bill a patient for any amount that a third-party payer is obligated to pay.

f. The Collection Agency, when notified, must send every patient a copy of the Notice of Rights. A Copy of the Good Bye Letter, when hospital charges present.

E. **Third Party Liability**. Nothing in this policy precludes Hospital affiliates or outside collection agencies from pursuing third party liability in a manner consistent with the Third-Party Lien Billing Practices.

F. For any contract creating a medical debt, a holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."

VI. REFERENCES:

A. FDCPA
B. HIPAA
C. TCPA
D. Internal Revenue Code Section 501 (r)
E. 26 Code of Federal Regulations 1.501 (r) – 1 through 1.50 (r)
F. California Health and Safety Code section 124700 through 127446
G. No Surprises Act
H. AB-532
I. AB-2297
J. SB-1061

VII. ORIGINATOR:

Patient Financial Services

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VIII. LEGAL REFERENCES:

None

IX. ACCREDITATION:

None

X. CROSS REFERENCES:

A. FDCPA
B. Policy # 01951.99, Health Information: Access, Use & Disclosure
C. Policy # 15602.99, Financial Assistance for Uninsured or Low Income Patients

XI. APPROVALS:

A. PFS Policy and Procedure Committee – 04/96; 12/01; 12/04; 12/06; 12/09; 08/10; 08/13; 03/ 15; 03/16; 09/16; 08/19; 06/24; 12/24; 07/2025
B. System Policy & Procedure Steering Committee – 05/96
C. System Planetree Committee – 07/24

XII. HISTORY:

System #15801; originally dtd 5/96
Revised/Reviewed: 12/01; 12/04; 12/06; 12/09; 08/10; 08/13; 03/15; 03/16; 09/16; 06/2024; 12/2024; 06/2025; 07/2025

A. Attachments

None

Approval Signatures

Step Description	Approver	Date
Administrator	Tamara Westgate: Prgm Mgr- Policies and Procedures	7/14/2025
	Amanda Escobedo: Training Coord- Revenue Cycle	7/14/2025

Applicability

Chula Vista, Coronado, Grossmont, Mary Birch, McDonald Center, Memorial, Mesa Vista, Sharp HealthCare

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