Effective:	*01/2017*
Approved:	*01/2017*
Last Revised:	*01/2017*
Expires:	*01/2018*
Author:	*Hope Kivlehan: Controller*
Policy Area:	*Patient Accounts*
References:	

Patient Financial Clearance Policy

I. PURPOSE:

Provide a detailed overview of the financial clearance and collections processes for hospital patients.

II. POLICY:

Grant Memorial Hospital (GMH) is committed to minimizing the expenses associated with the recovery of patient account balances. It is the intent of GMH to identify and collect all patient account balances, preferably, prior to or at time of treatment or immediately following. Prompt identification and collection of these balances will increase cash flow while minimizing the cost of collections, statements and postage.

DEFINITIONS:

Co-Insurance is a percentage of the total charge that is due from the patient for each service event. These amounts are deducted from the hospital's contracted rate of payment with the expectation that the hospital will recover this portion from the patient.

Co-payment is typically a flat amount or fixed fee due from the patient, based upon their medical plan for specific medical services covered by the plan. Co-payments typically apply to each date of service.

Deductible is typically a flat amount due from the patient, as required by the insurance carrier, based on the provisions of the patient's insurance policy. This amount may apply to each date of service or on an annual basis. *Note: This amount may not always be satisfied within one visit.*

Non-covered charges refer to hospital charges that will not be reimbursed by a third party payer due to the type of charge, place of service, diagnosis, limits of coverage and effective dates of coverage based upon the provisions of the patients insurance policy.

Non-urgent refers to patients who do not require expedited care. See definition of urgent.

Normal Business Hours are Monday -Friday between the hours of 9AM and 4PM.

Underinsured are patients who have insurance that does not completely cover the fees for medical services.

Uninsured are patients who do not have any insurance coverage for medical services.

Urgent refers to patients who require **expedited care** (within one business day or the same day) for medical reasons or the physician's request.

Resident refers to a person whom resides at GMH with no specific moving date.

III. PROCEDURE:

PATIENT ACCESS / FRONT-END PROCESSES

A. **Scheduling of Patient Services**

1. Scheduled patient services including inpatient, outpatient surgery, and all applicable outpatient services should be scheduled at least one (1) week in advance whenever possible.
2. Non-urgent patient services requiring authorizations/certifications, as defined by the patient's insurance policy, **must be obtained before patient is put on the schedule**.
3. Any uninsured patient, requiring non-urgent services, should be referred to a Financial Counselor for financial clearance prior to scheduling hospital services.
4. Data collected at the point of scheduling must include:
    a. Key patient data
    b. Essential Medical Insurance Information
    c. Ordering Physician
    d. Supporting diagnosis codes for scheduled test/procedure
    e. Applicable Authorization/Referral #'s
    f. Copy of physician's order

B. **Pre-registration of Patient Services**

1. Scheduled patients should be pre-registered two (2) to three (3) days prior to the expected date of service.
   Note: With the understanding that add-ons will occur on a *daily basis.*
2. The pre-registration process should include the following:
    a. Perform **insurance verification** (IV) on all insurances on the account. The IV process should include confirmation and documentation of:
        i. Insurance ID / Group number
        ii. Effective dates of coverage
        iii. Authorization and referral requirements
        iv. Coverage for specific services provided
        v. Run Price Estimator
        vi. Applicable patient deductibles, co-pays and non-covered amounts
        vii. Scan all applicable paperwork
    b. For Medicare and Medicare Advantage outpatients, check for **medical necessity**. If medical necessity requirements are not met, contact ordering physician in an effort to resolve this issue.
    c. Contact patient regarding:
        i. Any Medicare/Medicare Advantage medical necessity issues where an Advanced Beneficiary Notice (ABN) may be required.

ii. For urgent patients, any insurance pre-certification/ pre-authorization requirements related to their policy should be communicated. Inform patient that their ordering doctor must obtain pre-certification/pre-authorization for their test and/or procedure prior to scheduling the patient at GMH.

iii. Collect any definitive patient responsibility (copay, coinsurance, deductible, deposit, or amount identified by Financial Counselor).

If payment cannot be collected at the time of pre-registration, inform the patient of the amount due a the time of service and their payment options.

NOTE: *Urgent uninsured patients that are put on the schedule after hours and come in the next day will be referred to the Financial Counselor after services are provided.*

d. Any patients identified as uninsured or underinsured should be verified for State Medicaid. If no coverage exists, the patient should be referred to a Financial Counselor for exploration of other potential payment options prior to the scheduled date of service.

Again, uninsured patients, requiring non-urgent services, should not be scheduled until financial clearance is approved by the Financial Counselor.

C. **Financial Counseling (for uninsured/underinsured patient services)**

1. Patients referred to a Financial Counselor, prior to or at the time of scheduling or preregistration, should be followed up on the same day or the following business day to determine a means for payment or assistance. Patients will be referred to the Financial Counselor via the physician office or scheduling and pre-registration. For uninsured walk-in patients, during "Normal Business Hours", these patients should be referred to the Financial Counselor before services via Instant Messaging (IM) when possible.
2. The Financial Counselor should make every effort to collect any payments due prior to providing the financial clearance for uninsured/underinsured non-urgent patients to be scheduled.
    a. **Uninsured/Underinsured – Financially Capable Patients**:
    See Section D below for payment options and also utilize the Price Estimator or Attachment A, if the estimator is unavailable.
    b. **Uninsured/Underinsured – Indigent and Marketplace Applicable Patients** :
    These patients should be asked to complete a Medical Assistance application or go to the Marketplace for insurance coverage prior to the expected services. A Financial Assistance application should also be completed if the patient:
        i. Is uninsured and refuses to go to the Marketplace
        ii. Has insurance but also has a high patient responsibility and cannot afford identified patient liabilities
        iii. Is a Medicare primary patient with a fixed income that qualifies for Financial Assistance
        iv. Is an extraordinary case identified by the state or hospital

        NOTE: *See the Financial Assistance Policy for additional information*

Once this is complete, the financial clearance outcome can be communicated to the scheduling or preregistration staff by updating the *FINANCIAL CLEARANCE UDPATE excel file on the shared drive.*

For uninsured/underinsured patients, the Financial Counselor should document in the patient account, the expected payment methodology (discount, deposit, payment plan, Medical Assistance or Financial Assistance application status).

Note: *Hospital approved payment plans should be handled as noted in D.3 below.*

D. **Guidelines for Patient Discounts. Deposits and Payment Arrangements**

1. DISCOUNTS – For **uninsured patients**, 20% of the estimated charges will be discounted **automatically** at the time of billing. Additionally, after the **20%** automatic discount, **account balances over $250 may receive an additional 25% discount if payment in full is made within 30 days of the first statement date**. If an uninsured account is paid within 30 days, the patient has the potential to receive an overall **40%** discount.

   For patient balances **after insurance** and **over $250**, a **25% discount will be permitted if payment in full is made within 30 days of the first statement.**

   GMH Employees are eligible for **an additional 25% discount** from the balance due after insurance and after an applicable prompt pay discount.

   ALL above discounts are **not-applicable to Extended Care Unit/Long-Term Care residents.**

2. DEPOSITS – For non-urgent uninsured patients, if payment in full cannot be made, a thirty percent (30%) deposit based on estimated charges is required as calculated from the Price Estimator or Attachment A, if the estimator is unavailable. If the patient has bad debt with GMH, refuses to apply for Medical Assistance or meet with the Financial Counselor, cannot produce proof of identification and/or nationality, a 100% deposit may be required.

3. PAYMENT ARRANGEMENTS - If necessary, remaining balances can be paid monthly in adherence with the following schedule:

PAYMENT PLANS	
Balance Range	Amount or Maximum Months Allowed
$ 25.01 – $ 250	$25 or 12 months max to pay
$ 251.01 – $ 900	$50 or 18 months max to pay (1)
$ 901.01 – $ 1,800	$75 or 24 months max to pay (1)
$1,800.01 & Up	*24 months max to pay (1)*

(1) GMH's Healthcare Financing Partner (HFP) may extend payment plans to 36 months, if the guarantor cannot financially meet the payment plan guidelines set above. Any payment plan arrangements beyond 36 months must be approved by the PFS Manager prior to setup.

a. Additionally, deposits or discounts approved prior to or at the point of service should be documented in the system account notes (estimated charges should be included in the notes if this was part of the calculation for payment).

b. Any expected payment plan arrangement should be documented on the patient's account. However, a payment plan should not be established in the hospital's system. All payment plans must be set up and managed by GMH's Self-Pay Early-Out Vendor (SPEOV). As a result, a payment plan arrangement must be emailed to the specified representative at the SPEOV for setup once the account is referred.

c. Via the SPEOV, patient 12 month Payment Plan monthly installments are due by the 15th of each month even if the prior month payment exceeded the installment amount. Additionally, these payment plans are set up as a courtesy to the patient with NO interest charges.

   i. The SPEOV explains the payment plan guidelines (see paragraph above) for the amount due based on the balance. Patients on payment plans are billed 20 days prior to the due date (a 10 day grace period is granted). If the consumer misses two (2) installments, account(s) can be reviewed for collections. If an account falls broken, the SPEOV places phone calls and sends broken promise letters. Additionally, the SPEOV follows up every 15 days on the account until it is either reset or paid. Lastly, the SPEOV requests that the consumer call if an address or any key information has changed or if they are going to be late or miss an installment due to financial difficulty.

d. If a guarantor payment plan must exceed 12 months, the guarantor will be referred by the SPEOV to GMH's HFP for payment plan setup. Once the payment plan is setup and the first payment is made, the total balance less the HFP fee will be funded to GMH by the HFP.

E. **Registration/Sign-in**

1. Notices are posted throughout the admissions and registration areas to alert patients that payment for insurance deductibles, coinsurance, co-pays and noncovered charges are expected prior to or at the time of service. All acceptable forms of payment are included as part of this notice.

   Note: *Emergency Room payments should be collected at the point of registration* ***following*** *physician screening.*

2. At the point of registration/check-in, Patient Access or the department staff will:

   a. Ensure patient's identity (e.g. Patient/Guarantor name, mailing address and birth date match to driver's license).

   b. Scan all physician orders and applicable authorizations/referrals at time of registration. Additionally, update existing scanned information with any new or additional information such as patient/guarantor driver's licenses and insurance cards. If patient/guarantor does not have a driver's license or other acceptable photo ID, a picture can be taken and stored in HMS.

   c. For emergent, urgent and walk-in patients that did not go through the pre registration process, verify the insurance as indicated in Section B.2.a of this policy, run the price estimator, and collect all applicable patient responsibilities. Also, see Attachment A.

   d. If the patient is a Medicare or Medicare Advantage patient, and was not pre registered, check to ensure medical necessity (contact physician office if medical necessity is not met). If physician

provides updated diagnosis information, an updated order must be obtained. If medical necessity cannot be obtained, have the patient sign an Advanced Beneficiary Notice (ABN).

3. For pre-registered patients, review and follow-up on any outstanding items from pre-registration and collect any applicable patient liability identified via the insurance verification process and price estimator that was not collected previously.

   Note: *This information should always be checked by reviewing the HMS Notes at the point of intake.*

4. During "Normal Business Hours," emergent, urgent and walk-In patients identified as uninsured or underinsured should be referred to a Financial Counselor prior to departing from the hospital.

After hours, for any patient identified as uninsured or underinsured, the registration representative should print out a face sheet for the patient for referral to the Financial Counselor for follow up within 1-2 business days.

Attachments:

Attachment A (Patient Financial Clearance Policy).pdf

Approval Signatures

Approver	Date
Janet Frye: BOT Chair	01/2017
Eleanor Berg: NP	01/2017
Scott Roberts: Medical Staff Director	01/2017
Hope Kivlehan: Controller	01/2017

DEPOSIT GUIDELINES FOR UNINSURED PATIENTS ATTACHMENT A

		Percentage of Charge Method	**Fixed Deposit Method**
Inpatient	Med Surg	30% of Estimated Charges	$1,200/Day
	Swing	30% of Estimated Charges	$ 460/Day
	Skilled	30% of Estimated Charges	$ 460/Day
Emergency Room	Level 1 - 99281		$ 75
	Level 2 - 99282		$ 125
	Level 3 - 99283		$ 200
	Level 4 - 99284		$ 200
	Level 5 - 99285		$ 500
OP Surgery		30% of Estimated Charges	See next page
Laparoscopic Cholecystectomy	47562, 47563 or 47564		$1,000
	Other		$ 500
Bone Scans	78300,78306,78315,78320		$ 200
	Other		$ 100
CT Scans			
	70450,71260,72192,74150,74170		$ 300
	Other		$ 150
Echocardiograms	Echo-93307, 93320, 99325		$ 400
	w/ Holter Monitor(93225,93226 & Other)		$ 200
MRI	70551,72141,72148, 73721		$1,000
	70553		$2,000
	Other		$ 350
PT/OT/ST	Evaluation (97001 or 97003)		$ 100
	97033, 97035,97110, 97140,		$ 30
	Speech 92507, 92507		$ 80
Stress Tests	93017		$ 200
	Nuclear Stress Test - 93017,78465,78478,78480,A9500		$1,000
	Nuclear Stress Test w/ Echo – 93017, 93307,		$1,000

	93320, 93325, 78465, 78478,78480, A9500		
	Other Nuclear		$ 500
Ultrasound	76705, 76830, 76805, 76856		$ 100
	93880		$ 200
	Other		$ 100
Surgery	11400 Excision, Benign Lesions		$ 200
	45330 Sigmoidoscopy		$ 200
	45378 Colonoscopy		$ 300
	45380 Colonoscopy, with Biopsy		$ 300
	52000 Cystourethroscopy		$ 300
	58120 D &C		$ 300
	11401-404 Excision, Benign Lesions		$ 300
	11406 Excision, Benign Lesions		$ 300
	11420-424 Excision, Benign Lesions		$ 300
	11426 Excision, Benign Lesions		$ 300
	11440-442 Excision, Benign Lesions		$ 300
	62311 Injection, Epidural Lumbar		$ 300
	64721 Neuroplasty, Carpal Tunnel		$ 300
	43239 Upper GI Endoscopy		$ 300
	29826 Arthroscopy, Shoulder		$ 500
	19120 Excision, Breast Cyst, Fibroadenoma, or Tumor		$ 500
	27814 Fracture, Ankle		$ 500
	23515 Fracture, Clavicular		$ 500
	58671 Laparoscopy		$ 500
	20680 Removal of Implants, wires, pins, screws, plates		$ 500
	55250 Vasotomy		$ 500
	58558 Hysteroscopy		$ 500
	Arthroscopy, knee w/ Meniscectomy		$ 600
	Arthroscopy, knee, Synovectomy		$ 600
	Arthroscopy w/ Meniscectomy		$ 600
	Hernia, repair Inguinal		$ 600
	Ostectomy, Calcansus, for spur		$ 600
	Tonsillectomy, age 12 or over		$ 600
	Arthroscopy, shoulder with rotator cuff repair		$1,000
	Rotary cuff repair		$1,000
	Spontaneous Abortion, treatment		$1,000
	Cholecystectomy		$1,000
	Cataract removal w/ insertion of Intraocular lens		$1,000