

St. Joseph's/ Candler Health System	Administrative Policy Title: Patient Financial Clearance	Policy Number: 1227-A Effective Date: 04/03/2019 Page 1 of 5
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Policy Statement

It shall be the policy of St. Joseph's/Candler Health System (SJ/C) to determine the financial ability of patients to pay for services provided by SJ/C at or before the point of service. This process will ensure that patients are properly educated as to their financial responsibility and that SJ/C maximizes collections of patient residual balances. In order to do this, we will require the physicians practicing at SJ/C to identify an order for services as Emergent, Urgent or Elective. This designation will assist in making financial decisions regarding the provision of services.

Emergent health care services will be provided to patients regardless of their ability to pay and are eligible for financial assistance to those who qualify. No patient shall be denied emergency care based upon their ability to pay, race, color, religion, creed, sex, national origin, age, disability, gender identity or expression. Criteria will be the same as those established under Emergency Medical Treatment and Labor Act (EMTALA) Laws and Regulations. For Urgent and STAT services, SJ/C will identify any patient financial responsibility prior to service and the patient/guarantor will be requested to pay or make acceptable payment arrangements prior to services being rendered. Patients seeking Elective services will be required to pay their portion at the time of service which could result in a combination of a time of service payment and payment plan that would then deem the patient financially cleared.

Purpose

- To provide a means by which health care services are available in a consistent, equitable and effective manner.
- To assure that those who require health care services are able to obtain such services while ensuring that appropriate financial arrangements are made prior to service being rendered.

Entities to whom This Policy Applies

Candler Hospital and St. Joseph's Hospital, including all off campus outpatient facilities.

Definition of Terms

Amounts Generally Billed (AGB) – The amount by which charges for *Uninsured* patients are measured. Uninsured patients will not be charged more for care than the AGB for patients who have insurance coverage. To calculate AGB, SJ/C uses the look-back method. The look-back method utilizes data from Medicare and private health insurers based on the prior 12-month fiscal year to determine the AGB percentage applied. The AGB percentage utilized by SJ/C and the method in which it was determined is available free of charge from the Customer Service Department. Customer Service may be contacted at 912-819-8455 or 800-374-7054.

Elective – Service that is beneficial to the patient, but is not considered urgent. Any service scheduled greater than 30 days out will be considered Elective.

Emergent – Service is needed immediately due to injury or sudden illness. Examples include difficulty breathing, suspected heart attack, uncontrolled bleeding or possible stroke.

Financial Assistance Policy (FAP) Discount – A percentage discount of the patient account balance based on the patient’s ability to pay.

Financial Counselors – SJ/C co-workers who secure payment of deductibles, co-insurance and other estimated self-pay balances, provide assistance for those unable to pay by referral for Medicaid or other state programs, and provide guidance with the FAP.

Insured – The status of a patient with insurance or third-party coverage which pays all or a portion of the patient’s gross charges for medical services.

Prompt-Pay Discount – A 5% discount of the patient’s self-pay account balance (including any deductible or co-insurance) if paid in full at the time of service or within 30 days of the statement date. This discount is an administrative adjustment and is not considered financial assistance.

Self-Pay Discount – A percentage discount of the patient’s self-pay account balance based on the patient’s Uninsured status. Uninsured patients are eligible for a Self-Pay Discount based on the most recent AGB.

STAT – Services ordered by a physician that should be performed without delay.

Underinsured – Patients who are covered by high deductible plans or the remaining patient balance is greater than the patient is able to pay.

Uninsured – The status of a patient without insurance or third-party coverage who does not qualify for Medicaid or other state assistance. A patient may also be classified as “uninsured” if the patient is insured, but the insurer refuses to pay for medical services rendered for reasons such as pre-existing conditions, out-of-network provider, etc.

Urgent – Unexpected illness or injury that needs prompt medical attention, but not an immediate threat to your health. Examples include headaches, back or joint pain, flu symptoms or ear aches.

Procedure

SJ/C will provide Emergent services to all patients. After EMTALA requirements are met, SJ/C will request payment of any deductible or co-insurance amounts prior to the patient being discharged.

Financial Clearance will be utilized for any patient who is self-pay or has coverage by only one insurance plan. Patients who are covered by Medicaid, Workers Compensation or by two insurance plans will not be screened unless the service provided is not covered by their insurance plan.

Post inpatient discharge care for certain individuals frequently include, but are not limited to Home Health, Wound Care Clinic and Physical Therapy for ongoing outpatient services and shall be considered medically necessary. These individuals are listed as Medicaid pending, Good Sam, St. Mary's or pending charity and will be considered cleared for financial clearance.

For all non-emergent care provided to patients, an estimate will be provided based on the services to be rendered and any out of pocket cost including deductibles, co-pays and/or co-insurance.

SJ/C **requests** payment of the deductible, co-pays, and co-insurance amounts for all Urgent services rendered to patients, with the exception of those who qualify for financial assistance under **Administrative Policy #1220-A Billing, Collection and Financial Assistance**.

SJ/C **requires** payment of any remaining deductibles, copays, and/or co-insurance amounts for any service deemed Elective by the patient's ordering physician. For Elective surgical services, patients will be required to pay 50% of the estimate to reserve the surgical time at time of pre-registration or a minimum of 14 days prior to the date of service, whichever is less. The remaining balance will be due on the date of service. Patients not willing to make a down payment or set up a payment plan to reach to the 55% required to reserve the surgical service will be informed that the surgery will need to be delayed.

Patients who wish to appeal the Elective determination may do so by contacting the Office of Medical Affairs at 912-819-6670 or 912-829-3338.

Exceptions will be made for screening services, such as mammograms and colonoscopies. All radiation oncology and chemotherapy services will be considered Urgent under this policy.

Except where prohibited by law or contract, SJ/C will look to the patient/guarantor for payment in full or financial clearance as defined below on all accounts. A brochure, outlining SJ/C payment guidelines, is available to patients and physicians.

A. Financial Clearance

Financial clearance is defined as the patient/guarantor making satisfactory financial arrangements for payment of the patient’s estimated deductible/co-insurance amounts as outlined below:

1. Payment in full for Elective services is required at the point of service. A Prompt Pay Discount of 5% of the estimated amount due is available for accounts paid in full at time of service.
2. Payment arrangements can be made for Urgent services. A down payment equal to one monthly payment amount should be requested at the point of service. In-house payment arrangements will not extend beyond 6 months. Payment plans beyond 6 months can be established with our partner AccessOne

Internal Payment Plan - OnPlan

Account Balance	Optimal Term	Secondary Term	Minimum Monthly PMT
\$100 - \$250	3 Months	4 Months	\$25.00
\$250.01 - \$500	3 Months	6 Months	\$41.67
\$500.01 and up	6 Months	-	\$83.34

Payment Plan with Partner, AccessOne

Account Balance	Number of Equal Payments
\$1,000 - \$3,000	12 Months
\$3,001 - \$6,000	24 Months
\$6,001 - \$9,000	36 Months
\$9,001 - \$13,000	48 Months

3. For Urgent services, if neither option above can be satisfied, the patient will be referred to a Financial Counselor.
 - a. Uninsured or Underinsured patients will be screened for Medicaid or other state programs. If determined eligible for these programs, the patient will be considered financially cleared.
 - b. If determined ineligible for those programs, the patient will be provided a Financial Assistance Application (Form #FN40111 found on the Forms Repository). Completion of the Financial Assistance Application, if ineligible for Medicaid or other state programs, will allow the patient to be financially cleared for services.

4. Being financially cleared for services in no way prevents the patient from being responsible for any remaining balances after insurance processes or if the patient is only deemed eligible for a partial Financial Assistance discount.

Patients seeking Elective services will be eligible for Financial Assistance or payment plans if the 55% estimate for the service is secured.

B. Scheduled Services

Scheduled services shall be defined as Urgent or Elective services that are scheduled at least 48 hours prior to the time of service. An estimate of the patient liability based on average charges per service and individual insurance benefit coverage will be calculated and communicated to the patient. Patients must be financially cleared prior to the services being rendered.

C. Unscheduled Services

Unscheduled services shall be defined as services that do not require scheduling or are scheduled less than 48 business hours prior to the time of service. The estimated patient liability for unscheduled services will be provided by the Patient Access Staff at the time of service. For unscheduled Urgent services, payment in full of the estimated amount due will be requested or the patient will be required to be financially cleared prior to services being rendered. It is recognized that in these instances, upfront financial counseling is not always possible; consequently, service may be delayed until the patient can be financially cleared. For unscheduled Elective services, payment in full of the estimated amount is required prior to services being rendered or service will be deferred. Payment in full can be defined as a combination of initial payment and meeting the appropriate terms of a payment plan in order to reach the 55% of estimate required for services to then be rendered.

D. Financial Counseling

Financial Counselors may be contacted by calling any of the phone numbers below:

St. Joseph's Hospital	912-819-3840
Candler Hospital	912-819-5083
SJ/C Oncology Services	912-819-5838

A financial clearance determination will be made as soon as it is feasible to do so. It may become necessary to postpone services until the patient is financially cleared.

E. Payment Options

Payment by check, debit card or credit card are accepted. SJ/C accepts Visa, MasterCard, American Express, and Discover Card. Payroll Deduction is available for co-workers receiving services.

F. Co-worker Accounts

Co-worker patient accounts will be handled in a manner consistent with the financial expectation of any SJ/C patient. In addition, co-workers may utilize payroll deduction as an alternative payment option for urgent services. If a co-worker elects to use payroll deduction, they will be responsible for completing a payroll deduction form for any new or additional accounts prior to services being rendered. Co-worker payroll deductions should be set established following the monthly payment guidelines stated above, withholding on a bi-weekly basis.

RESPONSIBILITY FOR INTERPRETATION

The Director of Patient Financial Services will be responsible for interpretation of this Policy.

Approved:



Original Implementation Date: 2/22/2017
Next Review Date: 04/03/2022
Originating Department/Committee: Patient Accounts
Reviewed: 03/17, 07/17, 03/19
Revised: 03/17, 07/17, 03/19
Rescinded:
Former Policy Number(s):
Cross Reference: Administrative Policy #1220-A Billing, Collection and Financial Assistance

Printed copies are for reference only. Please refer to the electronic copy for the latest version.