VALLEY MEDICAL CENTER
PATIENT ACCESS POLICIES AND PROCEDURES
FINANCIAL CLEARANCE

Department	Patient Access
Subject	Financial Clearance and Medically Appropriate Deferral of Services
Procedure	A 200
Effective Date	April 2009
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PURPOSE:

To determine the appropriate payment source and ensure the account is financially secure before the service date, minimizing losses related to non-emergent or non-urgent services where the patient or their payer has not provided reasonable assurance or commitment for payment.

POLICY:

1. Valley Medical Center's policy is to ensure that all non-emergent admissions and procedures are screened and authorized by the payer before services are rendered. Additionally, payment arrangements must be established for the patient's liability portion of services, as well as any outstanding balances exceeding $2,000 (up to 12 months old) owed by the patient.

2. Failure to provide appropriate authorization and/or financial clearance may cause the organization to delay services until authorization and/or financial clearance has been obtained.

3. This policy also emphasizes the importance of obtaining financial clearance for patients who are classified as "uninsured."

4. Valley Medical Center will make sure those patients who are uninsured and/or underinsured are evaluated for their ability to pay and the most effective method for resolving their account. This policy covers all patients who access the organization from any entry point.

5. Obligation for payment for health care services becomes effective when services are scheduled.

6. In no event will a patient be denied treatment in the Emergency Department or Birth Center because of financial issues; this policy is in full compliance with the rules and regulations of EMTALA.

PRE-ACCESS SCREENING

Procedure:

1. <u>Patients requesting non-emergent / non-urgent services at Valley Medical Center</u>

   Patients requesting non-emergent/non-urgent services at Valley Medical Center will be pre-screened prior to service(s).

2. <u>Authorized service with a high deductible and/or any large prior balance(s)</u>

   Financial Advocacy Coordinator will contact the patient to explain the situation and establish a payment arrangement that includes a deposit of at least 50% of the allowed amount and a payment plan for the remaining balance(s).

3. Patients that have services scheduled but lack prior authorization:

   - Financial Access will provide a courtesy notification to the physician's office 72 hours before the scheduled service. A final review of prior authorization will take place 48 hours before the service. If prior authorization is still not on file, the patient's scheduled service will need to be deferred. The Financial Advocacy team will inform the physician's office that the service must be postponed until prior authorization is obtained. The physician's office will be responsible for notifying the patient.

   - If the physician requests administrative approval based on a "life or limb" situation and a pending prior authorization is on file, the Manager, Financial Access will request a "management authorization." to proceed with the services. Final determination will be based upon clinical evaluation by the Chief Medical Officer (CMO) and financial evaluation by the Chief Financial Officer (CFO).

   - If patient chooses to pursue services as self-pay, without authorization approval, they will be subject to Uninsured Patient guidelines below.

4. Uninsured Patients

   All uninsured patients will be required to pay 100% Patient Financial Responsibility (PFR) minus any applicable uninsured and prompt pay discounts prior to services being rendered.

   - Prior payment history and bad debt assignments may be reviewed to determine eligibility for a 50% deposit.
     - The deposit is calculated as 50% of gross charges minus any applicable uninsured discounts

   - Prompt payment discounts are not available for patients who opt to pay 50% upfront and arrange payment plans for unpaid balances.

   - VMC payment plan for a minimum of $50 per month and/or 12 months (see Payment Plan Policy).

   - Payment plans may be offered through the loan payment vendor for the remaining balance

   - If no payment options are established or arrangements are made, the service will be postponed until the patient addresses their financial liability

   - If the physician requests administrative approval based on a "life or limb" situation, the Manager, Financial Access will request a "management authorization." to proceed with the services. Final determination will be based upon clinical evaluation by the Chief Medical Officer (CMO) and financial evaluation by the Chief Financial Officer (CFO).

   - Once the patient has established a payment plan for their financial responsibility at Valley Medical Center, services can be scheduled / rendered.

DOCUMENTATION STANDARDS:

All financial clearance activity will be noted in Valley Medical Center's information system for reporting, tracking and productivity purposes.

DEFINITIONS:

1. **Authorization:**
   Formal approval or consent given by an insurance provider or payer to approve a specific medical service, treatment, procedure, or medication

2. **Pre-Certification:**
   Process where a healthcare provider obtains approval from an insurance company before delivering certain services or treatments. It is typically required for elective procedures, hospital admissions, or specialized treatments to ensure they are medically necessary and covered under the patient's insurance plan.

3. **Medical Necessity: Services or supplies which meet the following criteria:**
   - Services, treatments, or procedures that are considered appropriate, reasonable, and essential for diagnosing or treating a medical condition based on current standards of care.
   - These services must be provided in accordance with accepted medical practices and should be necessary to prevent, diagnose, or treat a patient's illness, injury, or condition.
   - Insurance companies often require that care be deemed "medically necessary" in order to be eligible for coverage.

4. **Uninsured:**
   Refers to an individual who does not have health insurance coverage. This means the person is responsible for paying the full cost of medical services out of pocket, without the financial assistance typically provided by an insurance plan. Uninsured patients may seek alternative payment arrangements, such as self-pay options or financial assistance programs, to help cover their healthcare expenses.

5. **Patient Financial Responsibility (PFR):**
   Refers to the portion of healthcare costs that a patient is required to pay out of pocket, which is not covered by insurance. This may include deductibles, copayments, coinsurance, or any other charges for services that exceed insurance coverage limits. PFR is typically outlined in the patient's insurance plan or determined through the billing process.

6. **POS (Point of Service) Estimates:**

   In healthcare, estimates refer to approximations of the expected costs or charges for medical services or treatments. These estimates are typically provided to patients before receiving care and are based on factors such as:

   - The anticipated services or procedures.
   - The patient's insurance coverage, including deductibles, copays, and coinsurance.
   - Applicable discounts or financial assistance for uninsured or underinsured patients.

   Healthcare estimates aim to help patients understand their potential financial responsibility, but they are not always exact and may vary based on unforeseen changes in the scope of care, additional services, or complications.

7. **Financial Clearance:**
   Refers to the process of verifying and confirming that a patient's financial and insurance information is accurate and up to date before a scheduled service or procedure. This includes confirming insurance coverage, obtaining necessary pre-authorizations, determining the patient's financial responsibility (such as copayments, deductibles, or coinsurance), and ensuring that payment arrangements are in place. Financial clearance is typically required to ensure that there are no financial barriers to care and that the healthcare provider will be reimbursed for the services rendered.

8. **Urgent:**
   Medical conditions or situations that require prompt attention but are not life-threatening or immediately critical. These situations typically involve symptoms or conditions that could worsen without timely care but do not pose an immediate risk to the patient's life**.**

9. **Emergency:**
   A medical condition or situation that requires immediate attention due to the potential threat to life, limb, or health. Emergencies often involve severe injuries, acute illnesses, or sudden medical events that demand urgent care to prevent serious outcomes or death