

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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Prepared by:	Kimberly Back Director Patient Access
Approval by:	Larry Smith CFO, Kathryn Beattie, CMO

**PURPOSE:**

To ensure that the appropriate source of payment is determined and the account is financially secure prior to the date of service, mitigating losses associated with services that are non-emergent/urgent in nature where the patient and/or their payer has not provided reasonable obligation and/or assurance for payment.

**POLICY:**

- 1) Valley Medical Center's policy is to ensure that all non-emergent admissions and procedures have been screened and authorized by the payer prior to services being provided, and that payment arrangements have been made by the patient for the patient liability portion of services and any outstanding balances or bad debt (up to 12 months old) that the patient may have. This policy also extends to the need to provide for financial clearance for those patients who are "uninsured."
- 2) Failure to provide for appropriate authorization and/or financial clearance will cause the organization to delay services until authorization and/or financial clearance has been obtained.
- 3) Valley Medical Center will make sure that those patients who are uninsured and/or underinsured are evaluated in terms of their ability to pay and the best way to clear the account (typically called "financial clearance"). This policy covers all patients who access the organization from any entry point.
- 4) Patient Access Services Management shall coordinate activities with other functional areas involved in the financial clearance process whenever possible.
- 5) Obligation for payment for health care services becomes effective when services are scheduled.
- 7) 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. Patients requesting non emergent services at Valley Medical Center will be pre-screened at the point of pre-access. Any patient who lacks pre-certification/authorization, has insurance coverage that will not cover the allowed amount due to unmet deductible or has any outstanding balance or debt with Valley Medical Center over \$1,000 (for the past 12-months) will be considered not financially cleared for their service and will fall within the terms of the Financial Clearance Policy.
2. Patients without prior outstanding balances and a good financial history:  
If they are not financially cleared for their scheduled procedure due to an unmet deductible for the scheduled procedure, the Pre-Access staff will request the Point Of Service (POS) estimated amount or Patient Financial Responsibility (PFR) and offer appropriate POS discounts. If the patient asks to be billed, after a review of the patients past financial history, patients who have a good financial record will be financially cleared and billed as requested with no POS discount applied. Patients who appear to have an unstable payment history will be referred to a Financial Advocate to set up a payment plan prior to service.
3. Patients with a previous outstanding balance, or unmet deductible:  
Patients who are unable to pay outstanding balances plus the POS estimate or PFR for the scheduled procedure during the Pre-Access phone call will be for options towards payment of their outstanding balances. The patient will be asked to pay 100% of prior bad debt amounts from within the last 12 months as well as 50% of the identified patient responsibility (for insured, co-pay and/or deductible amount; for uninsured, gross charges minus the uninsured and prompt pay discount).
4. Unauthorized procedure or authorized service with large deductible so that service is not reimbursed by payer:  
**The patient and physician's office will be notified that the service may need to be rescheduled if payment is not secured prior to service.**  
If an account lacks pre-certification/authorization for the service scheduled, or if there is a large enough deductible so that the allowed amount will not be paid by the payer, the Financial Advocate will notify the Physician office of the need to defer the service until financial clearance (obtaining pre-cert/auth and or clearing large prior balance) can be obtained.  
  
If the insurance has not pre-authorized the services or if the insurance plan has an unmet deductible and will not be paying for the services, the Financial Advocate will call and explain the circumstances to the patient and set up a payment arrangement requiring no less than a deposit equal to 50% of the allowed amount and a payment plan for the balance.
5. If the physician requests administrative approval based on "life or limb" status, it is our policy to inform and request approval from the CFO and CMO. When approved, the service will be rendered and the remaining steps will not be followed.
6. If the patient cannot pay the balance of prior bad debt and current liability in full prior to service, a 50% deposit and a six (9) month interest free payment plan for the balance will be offered and the option of completing full applications for financial assistance and/or Medicaid (if the patient is uninsured) prior to service. Longer payment plans can be offered through a bank-financing vendor.
7. If none of the arrangements is carried out, the service will be deferred until the patient makes arrangements to clear his or her liability.
8. Once the patient has developed a path towards repayment of their debt with Valley Medical Center they will be allowed to have services rendered.

## ADDITIONAL REQUIREMENTS:

1. The responsible party (the individual who accepts the legal obligation to pay for the medical services) will also be required to sign the Financial Consent/Financial Responsibility at the time services are rendered.
2. A patient will be registered as a self-pay patient (uninsured), subject to the financial clearance process just described if:
  - a) The contract holder for the primary insurance coverage refuses to sign an Assignment of Benefits; or,
  - b) The patient refuses to sign a Release of Medical Record Information, Statement of Financial Responsibility; or,
  - c) Authorization was denied.
3. Patients will be financially cleared prior to discharge. Patient Access Services management will be responsible for ensuring that procedures are in place to financial clear patients prior to discharge.

## 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:** A health plan's system of approving payment of benefits for services that satisfy the plan's requirements for coverage.
2. **Pre-Certification:** Typically, a requirement that a plan member or the physician in charge of the member's care notify the health plan and gain approval, in advance, of plans for a patient to undergo a course of care such as a hospital admission or complex diagnostic test.
3. **Medical Necessity:** Services or supplies which meet the following criteria:
  - A. They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition;
  - B. They are provided for the diagnosis or direct care and treatment of the medical condition;
  - C. They meet the standards of good medical practice within the medical community in the service area;
  - D. They are not primarily for the convenience of the plan member or a plan provider;
  - E. They are the most appropriate level or supply of service, which can safely be provided.
4. **Uninsured:** An individual who does not have "coverage" related to payment for their hospital/healthcare expense through a non-governmental third-party commercial and/or managed care payer or through a government sponsored payer such as Medicare or Medicaid.
5. **Financial Clearance:** Patients who have met the following criteria are considered financially cleared:
  - Insurance benefits have been verified for coverage and pre-certifications/authorizations have been obtained or acceptable payment arrangements have been made for any identified patient liabilities. Also, all necessary demographic and insurance information has been provided to facilitate billing and reporting

- requirements, and outstanding balances have been reviewed.
  - The patient may qualify for assistance through Medicaid or other funding sources as identified by the Financial Advocate and as supported by applicable tools. The patient is compliant with information required of said programs.
  - Valid signatures are on file for financial responsibility, Medicare Secondary Payer (MSP) assignment of benefits and releases of information as appropriate.
  - All identified patient responsible amounts and/or deposits will be collected pursuant to accepted protocols to include prior to service, at the time of service, and at discharge.
  - Valley Medical Center will insure that full communication of expectations occurs at the earliest possible/compliant point within the patient's care/service pathway.
6. **Urgent** – Term used to describe the condition of a patient requiring admission to the hospital for a clinical condition that would require admission for diagnosis and treatment within forty-eight (48) hours, otherwise the patient's life or well being could be threatened.
7. **Emergency** – Term used to describe a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
- i. Serious impairment to bodily functions, or
  - ii. Serious dysfunction of any bodily organ or part