POLICY TITLE: Financial Clearance (Patient Access)

CATEGORY: Patient Access
ORIGINATION DATE: 08/01/2018

SUB-CATEGORY: Patient Access
PUBLICATION DATE: 08/15/2018

Policy

The XXXX Financial Clearance Policy defines procedures that drive identification and resolution of financial risk, as well as steps for service deferral escalation, determination, and execution. The overall goal is to mitigate financial risk to XXXX while ensuring a consistent patient experience across the system.

Scope

XXXX is committed to providing medically urgent services to patients regardless of their ability to pay. This policy applies to all patients scheduled to receive non-medically urgent hospital services. This policy includes all hospital-based services, except:

1. Urgent/emergent services including all services covered under the Emergency Medical Treatment and Labor Act (EMTALA)
2. Organ and bone marrow transplant patients will follow existing transplant policies and processes
3. Behavioral Health patients will follow the existing policies and processes
4. Services associated with Provider Based Billing (PBB)
5. Package pricing for non-medically urgent services (e.g. cosmetics, bariatrics, etc.)

Financial Risk Categories

The Financial Clearance Policy applies when a planned service meets one or more of the financial risk categories listed below. Once identified as a possible financial risk, the responsible party will follow the applicable procedure as outlined in this policy in order to determine if service deferral steps may be necessary (see the ‘Procedures, Guidelines, Roles, and Responsibilities’ section).

1. Patient Liability Risk – patients that will have a financial liability as a result of a service and cannot or will not supply payment as required by the Minimum Deposit Guidelines in this policy. Sub-categories include:
   a. Uninsured – patients who do not have active health insurance coverage
   b. Balance After Insurance – patients who have active health insurance coverage with benefits for their upcoming service, but have a share of the financial responsibility (e.g., copay, coinsurance, deductible)

2. Non-covered Risk – patients with active health insurance that does not cover the services in question, including out of network plans. Also includes patients with Medicare coverage where services would not meet medical necessity guidelines.

3. Pre-authorization Risk – planned services that currently do not have a referral/pre-certification/pre-authorization where one is required in order to be reimbursed by the responsible payer

Medical Urgency and Exceptions: If the planned service is deemed to be medically urgent or qualifies for a management or provider exception, then the service deferral escalation process will not occur. Exceptions will be documented and tracked.

Procedures, Guidelines, Roles and Responsibilities

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If one or more financial risks are identified during the financial clearance process, the steps outlined for the risk categories below should be taken. If unable to secure the account, the scheduled appointment may be deferred until the encounter is financially cleared. All defined risks must be resolved prior to moving forward with the scheduled service - see ‘Service Deferral Determination’ section of this policy.

**Patient Liability Risks**

**Uninsured** – if a patient is uninsured with no active health insurance coverage, they will be asked to pay a minimum deposit prior to service as outlined in the Minimum Deposit Schedule. Uninsured patients are eligible for a discount on billed charges according to the *Uninsured Discount Policy*. See ‘Payment Arrangement Guidelines’ and ‘Service Deferral Determination’ sections of this policy for additional details.

**Balance After Insurance** – if a patient has an insurance plan which does not cover 100% of the required payment for their scheduled service, they will be asked to pay a minimum deposit prior to service as outlined in the Minimum Deposit Schedule. See ‘Payment Arrangement Guidelines’ and ‘Service Deferral Determination’ section of this policy for additional details.

**Medicaid, Govt. Programs, and Financial Assistance:** patients that are unable to pay will be offered the opportunity to speak to a financial counselor for possible enrollment in financial assistance programs. Enrollment in these programs may allow the patient to avoid service deferral. Management will determine whether positive pre-service progress towards enrollment in assistance warrants service deferral avoidance.

**Non-covered Risks**

If the patient’s coverage does not cover the planned services, the HBA will inform them that the services will not likely be covered by their insurer. Then they will provide them with the following options:

1. **Cancel services and reschedule with a contracted provider that covers service, or reschedule for a similar service that might be covered** – if the patient chooses this option, the Health Benefit Advisor (HBA) will move forward with service deferral escalation via the ‘Service Deferral Determination’ steps in this policy.

2. **Proceed with service - bill insurance but commit to signing a ‘Non-Covered Procedure’ waiver** – if choosing to proceed:
   a. HBA notifies the patient that they will be required to sign the ‘Non-Covered Procedure’ waiver at time of service
   b. HBA asks the patient to pay a minimum deposit prior to service as outlined in the Minimum Deposit Schedule. See ‘Payment Arrangement Guidelines.’ The required deposit will be based on the estimated out-of-pocket as assessed against the patient’s insurance benefits.

   If the patient agrees to sign the waiver, the HBA will notate as such so that the check-in staff know to ask the patient to sign it when they arrive for service. Proceed with service - do not bill insurance and register as self pay.

3. **Proceed with service – opt out of using insurance benefits**
   a. HBA notifies the patient that they will be required to sign the ‘Waiver of Insurance Benefits’ waiver at time of service
   b. HBA asks the patient to pay a minimum deposit prior to service as outlined in the Minimum Deposit Schedule. See ‘Payment Arrangement Guidelines.’ The minimum deposit will be reduced based on the self pay discount.

**Refusal to sign waiver at time of service:** If after committing to an HBA that they will sign a waiver, the patient then refuses to sign the waiver at time of check-in, then the patient will not be allowed to proceed with service. If needed, management may exercise the use of a management exception in order to proceed with service. See the Management Exception section later in this document.

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Pre-authorization Risks

When the patient’s active coverage for the planned service requires authorization, pre-certification, or a completed physician referral for services (all of these referenced generally going forward as ‘pre-authorization’), the pre-authorization must be obtained ahead of the planned service date to avoid service deferral. The following steps detail the process by which HBAs may end up needing to move forward with service deferral determination.

1. **4 Business Days Out (Escalation)** – when pre-authorization is required but has not been obtained four days prior to service, or as soon as possible following scheduling if the service date is closer than four days away, the HBA will contact appropriate parties to escalate the situation. Specific actions may vary based on the responsibilities of the HBA in the specific region in which they operate.
   a. If the HBA is responsible for procuring the authorization, then the HBA will ensure all necessary due diligence is performed in order to escalate and expedite receipt of the authorization. At this time, it may be appropriate to call the patient to inform them of the situation and ask if they are willing to call the payer directly to help escalate.
   b. If the referring provider is responsible for procuring the authorization, and the HBA is providing an authorization gatekeeping function, then the HBA should contact the provider’s office to escalate and ask for an expedited response. They should also inform the provider that the service may need to be deferred if the authorization is not obtained timely. It may also be appropriate at this time to call the patient and inform them of the situation, up to and including asking them to call the provider office and/or the payer to escalate.

2. **On the Day Prior to Service (Notification of Reschedule)** – if a pre-authorization is required, but not obtained at least one business day prior to the service, the HBA will again contact the applicable party (referring provider and/or payer) to attempt to obtain the pre-authorization. If the HBA is unable to obtain the pre-authorization, they will follow the ‘Service Deferral Determination’ procedure. For surgeries, notification of reschedule will be completed at 3:00pm the business day prior rather than anytime on the business day prior to service.

3. **Moving Forward Without an Authorization**
   a. The HBA will contact the patient to explain that their insurance may not cover the cost of the service and will offer the following options:
      i. **Commit to signing a ‘Non-Covered Procedure’ waiver** – the HBA will ask the patient to commit to signing a waiver stating that the patient will assume financial responsibility for the related service if authorization is not obtained and will ask the patient to pay at least the minimum deposit required by the Minimum Deposit Schedule if they want to proceed with service. See ‘Payment Arrangement Guidelines.’ If the authorization is obtained and a patient payment is no longer required, the pre-service deposit will be refunded (if there are no other outstanding balances). If the patient commits to signing the waiver, the HBA will notate as such so that the check-in staff know to ask the patient to sign it when they arrive for service. If the patient then refuses to sign the waiver at time of check-in, then the patient will not be allowed to proceed with service. If needed, management may exercise the use of a management exception in order to proceed with service. See the Management Exception section later in this document.
      ii. **Reschedule service until a later date** – the Patient Access Associate will attempt to defer service until authorization can be obtained; see ‘Service Deferral Determination’ section of this policy.

**Add-ons:** non-medically urgent add-ons represent a heightened risk both for Centura’s reimbursement as well as for the patient’s experience with the financial clearance process. These visits will follow the same rules as other planned services. Because the services are scheduled within two days from service, they would immediately qualify for possible deferral escalation if pre-authorization is incomplete.

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Service Deferral Determination

The service deferral determination process is the procedure by which responsible parties determine whether service deferral for planned, non-urgent services may be required. The steps are as follows:

1. **Medical Urgency** – the HBA will contact the referring provider’s office via phone to determine if the upcoming service may qualify as medically urgent
   a. If the encounter is deemed medically urgent by a Clinic Approver from the referring provider’s office, the service will proceed as planned
   b. If a Clinic Approver is unavailable to provide a medical urgency determination, the service will proceed as planned
   c. If the Clinic Approver reviews the situation and determines that the service can be safely deferred, then the deferral process will continue, and the service may be deferred

2. **Deferral Escalation Process**

   The Deferral Escalation Process is initiated at various times prior to service depending on the type of service being provided:

   **Deferral Escalation Criteria Chart**

<table>
<thead>
<tr>
<th>Service Level</th>
<th>Time of Deferral</th>
<th>Approval Level</th>
</tr>
</thead>
</table>
   | Surgical and Outpatient Procedures | No later than 3 p.m. the business day prior (e.g., Friday at 3 p.m. if service is the following Monday) | **Patient Access:**
   |                              |                                                       | - PA Associate                          |
   |                              |                                                       | - PA Manager or Supervisor              |
   |                              |                                                       | - PA Director as needed                 |
   |                              |                                                       | - CFO as needed                         |
   | All Other Elective Services  | During business day prior (e.g., at some point on Friday if service is the following Monday) | **Provider:**
   |                              |                                                       | - Provider                              |
   |                              |                                                       | - Clinic Leader or Appointed Delegate   |

a. **Discuss Deferral Situation with the Clinic** – upon determination that the planned service is not medically urgent, the HBA will discuss deferral with the clinic. This may occur during the medical urgency determination call or during a follow-up call when the clinic returns the call back to the HBA.

b. **Escalation to Clinic Approver** – upon hearing from the HBA that the service may be deferred, the party that received notification of the situation (answered the call) will escalate the service in...
question to the Clinic Approver (if the initial call answerer is not the approver):

i. **Provider Exception** – if the Clinic Approver does not agree that service should be deferred, the clinic will notify the HBA that the service in question qualifies for a Provider Exception. Service proceeds as scheduled, and the service deferral determination process is complete. The HBA will apply the appropriate account flag (billing indicator) must be applied.

ii. **Clinic Supports Deferral** – if the Clinic Approver agrees that service should be deferred, service is will be deferred, and the appropriate party notifies the patient and scheduler that service must be rescheduled:
   - **Provider is Involved** – if the provider is involved with service, the applicable scheduler will contact the patient to reschedule and keep the provider abreast of changes. The HBA will continue working to financially clear the patient.
   - **Provider is Not Involved** – if the provider is not involved with service, the HBA will contact the patient to notify of service deferral and will also notify the applicable scheduler to reschedule the service (ideally via warm transfer on the same phone call). If the HBA has authorization to adjust the schedule themselves, they may do so while on the phone with the patient.

3. **Management Exception** – Patient Access leadership reserves the right to override the deferral determination process when needed to ensure exceptional patient and provider service. In these situations, a non-standard payment arrangement or other accommodation may be made in accordance with the Patient Access leadership’s decision. This could happen pre-service or at the time of service. Exceptions to the deferral criteria should be rare but they may happen in some of the following example cases:
   a. Patient has insurance coverage that is likely to cover a substantial portion of the charges, despite the patient not being willing or able to pay their share of the cost
   b. Patient has a solid track record of paying bills at Centura
   c. Patient is overtly upset is willing to do whatever is necessary to receive service
   d. Patient or Provider have experienced other customer service mishaps at XXXXand this is an opportunity to perform service recovery
   e. Other cases yet to be defined

Each time a Management Exception is exercised, it must be noted with an appropriate flag (billing indicator) and the reason must be noted in the account notes.

4. **Patient Not Contacted Prior to Service** – if the patient cannot be contacted prior to service, but has a financial risk that would otherwise qualify them for deferral, use the following guidelines to determine how to proceed:
   a. If patient is insured and missing an authorization, they must sign a ‘Non-Covered Procedure’ waiver in case the procedure ends up being denied. If they do not sign the waiver, they must be deferred until Financial Clearance is completed.
   b. If the patient is a self-pay, they must pay their minimum deposit. If the patient requests financial assistance, they must still pay their minimum deposit or be deferred until the financial assistance is confirmed.

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**Payment Arrangement Guidelines**

This section defines the criteria for determining the minimum payment due for upcoming liabilities.

**Estimated Liability for Planned Service** – when a patient has an upcoming service with an estimated liability, the Patient Access Associate should request a payment amount of 100% of liability (amount will be adjusted for self pay patients based on the *Uninsured Patient Discount*). The patient may commit to

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paying at time of service, however, if they do not pay or sign-up for a payment plan after making that commitment, the service will be deferred.

If the patient is unwilling or unable to pay, the following guidelines should be adhered to:

1. If the patient is unwilling or unable to pay 100% of their liability, the HBA should then negotiate until reaching the minimum deposit. See the Minimum Deposit Schedule.
2. If the case is determined to meet requirements to be deferred, the patient should then be informed that if they are not willing to make the minimum deposit, that their service will be considered for deferral and may need be rescheduled until satisfactory payment arrangements can be made.
3. If the patient is unwilling or unable to pay the required minimum deposit, as need the cases can be escalated to a member of the management team for review.
4. The HBA should then ask if the patient would like to set up a payment plan for the rest of their liability.

### Minimum Deposit Schedule

<table>
<thead>
<tr>
<th>Estimated Patient Liability</th>
<th>Required Minimum Deposit</th>
<th>Example Out-of-Pocket Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $100</td>
<td>100%</td>
<td>$0 - $100</td>
</tr>
<tr>
<td>$101 - $1,000</td>
<td>$100 or 50% (whichever is higher)</td>
<td>$100 - $500</td>
</tr>
<tr>
<td>$1,001 - $2,500</td>
<td>$500 or 35% (whichever is higher)</td>
<td>$500 - $875</td>
</tr>
<tr>
<td>$2,501 - $10,000+</td>
<td>$875 or 25% (whichever is higher)</td>
<td>$875 - $2,500+</td>
</tr>
</tbody>
</table>

**Upfront collections must be compliant with 501(r) requirements related to Amount Generally Billed (AGB). See Financial Assistance Policy for details.**

### Definitions

1. **Financial Clearance** – the process of ensuring patients, providers, and payers satisfy financial and administrative obligations prior to scheduled service such that the service will likely be reimbursed.
2. **Medically Necessary** – any service or procedure reasonably determined by the patient’s treating provider to prevent, diagnose, correct, cure, alleviate, or avert the worsening of conditions that endanger life. Insurance payers typically maintain their own definitions for what qualifies as Medically Necessary.
3. **Medically Urgent** – any service or procedure that requires the patient to receive immediate medically necessary treatment no later than the provider-requested service date (typically within a business day or two).
4. **Add-on** – any service that is scheduled same-day or next-day.
5. **Pre-certification** – the process whereby a patient’s insurer (or third-party intermediary) confirms eligibility and collects information prior to inpatient admission and selected ambulatory procedures and services. Upon approval, the insurer provides a pre-certification reference number in addition to the number of days the patient is covered for the admission.
6. **Pre-authorization** – an acknowledgement and approval by the patient’s insurer that a patient will be...
receiving specific medical services within a specified timeframe. The insurance company provides an authorization number for the service(s).

7. **Clinic Approver** – the clinic leader (e.g., Practice Manager or Office Manager) or provider who confirms whether service meets deferral criteria
8. **Service Deferral** – when a planned service is cancelled or rescheduled

**References**

1. Uninsured Discount Policy
2. Financial Assistance Policy
3. Outpatient Tests and Services Policy
4. Non-Covered Procedure Waiver

**REVIEW/APPROVAL SUMMARY**

| REVIEW/REVISION DATES: | See Overview |
| APPROVAL BODY(IES): Corp. Responsibility, Director, Revenue Mgmt-Patient Access | APPROVAL DATE: 08/15/2018 |