JEFFERSON HOSPITAL
LOUISVILLE, GEORGIA

Title: Collections Policy- BUS-06	Original Date: 11/1/18
Department: Business Office/Registration	Effective Date: 11/1/18
Approved by: Department Manger	References:

POLICY:

This policy applies to patients who have a balance under one of the circumstances (A - E below) that would create a financial responsibility for the patient. These patients do not qualify for financial assistance as designated by the hospital Financial Assistance Policy.

Generally, a patient and/or guarantor will have a self-pay liability under the following circumstances:

A. The patient has no health care coverage for facility services.

B. The patient has health care coverage for facility services; however, the service to be rendered is not covered by his or her health care coverage (example, cosmetic surgery).

C. The patient has health care coverage, however, upon verification of the health care coverage, it is determined that the patient has a cost share amount due. This amount may come in the form of an annual deductible, applicable coinsurance, or copayment for facility services rendered.

D. The patient has a penalty for out-of-network services. This penalty is imposed by payers when, a patient is treated by an out-of-network facility, and/or physician. The penalty will vary based on the patients' hospital coverage.

E. The patient has exhausted his or her health care coverage for the current benefit period (benefit year, calendar year, and/or lifetime maximums).

PROCEDURE:

If a patient/guarantor has facility health care coverage use the following guidelines for determining and/or collecting self-pay balances:

A. **Medicare Inpatient Deductible**
The Medicare Inpatient Deductible for 2019 is $1,340.00.

B. **Medicare Outpatient Co-insurance**
The Medicare outpatient co-insurance is 20% of the APC rate for the procedure. The Medicare rates can be found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/. If the service rendered does not appear on the procedure listing, refer to the appropriate Medicare Fee Schedule based on the service

rendered (Rehab, MRI, CT, Mammograms, Clinical Lab, Nutritional Counseling, Diabetes Education, etc.)
Please advise beneficiary that this is an estimated out-of-pocket expense. If the liability is greater, patient will be billed for balance. If it is less than collected amount, patient will be refunded the excess amount

C. Medicaid
Generally, there are no recipient/patient out-of-pocket expenses for covered services. Based on the Medicaid level of coverage, however, there may be an out of pocket expense for **coinsurance and/or a noncovered service**.

D. Commercial and Managed Care Payers
Confirm patient's responsibility or out of pocket expense/price on the insurance card, by verifying the electronically (or Payer website) or contacting the payer. Verify if there is a patient responsibility and/or a non-covered service. Obtain the cost share amount and inform the patient. If unable to verify via the Payer website, the copayment amount can be found on the patient's insurance identification card. As a last resort, contact the corresponding payer directly.

Inpatient and Outpatient Elective Admissions, Same Day Surgery and Outpatients in a Bed (Scheduled Visits)

A Patients, with or without insurance must be **financially cleared**:
1. Prior to or on the date of pre-admission testing; or
2. No later than 12:00 Noon, two (2) business days prior to the procedure

The term **"financially cleared"** refers to insurance verification, the collection of all out-of-pocket expenses for all patients and the attainment of all required pre-certifications, authorizations, and/or referrals for those patients with insurance. For those with insurance, out-of-pocket expenses may include deductibles, coinsurance, and co-pay amounts, as well as all costs that are excluded from coverage (non-covered procedures). For those without insurance, out-of-pocket expenses are subject to the hospital self-pay rates.

If a patient is not financially cleared, within the stated time frame, the Supervisor for the service area will be notified and will subsequently make a determination as to the urgency of the patient's condition regarding the procedure/test.

Pre-admissions
Jefferson Hospital will pre-register all elective services when possible. The method of payment should be identified prior to the patient being admitted, including self-pay portions and prior outstanding balances.

Financial assessments will occur prior to the patient's scheduled procedure. If necessary, the Financial Counselor will secure a financial agreement prior to the patient's scheduled procedure based on the payment alternatives outlined in this policy or in the Financial Assistance Policy.

Emergency Room
When a patient is registered for Emergency Room services, the Registration clerk will follow all EMTALA guidelines, making sure the patient has been stabilized according to policy, prior to obtaining insurance information. Once EMTALA guidelines are met, the Registrar will request and make a copy of the patient's picture I.D. and any insurance cards provided. If the patient states they do not have any insurance, the Registrar will screen the patient for Medicaid eligibility through the Medicaid GAMMIS web portal. A copy of the GAMMIS results will be scanned into

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the patient's account. If no insurance is found, the patient will be registered with the financial class "Private Pay".

If the patient states that they have insurance, the Registrar will verify eligibility via tools provided, and notify the patient of their financial responsibility at the time of service including any co-pays or deductibles owed. In addition, the patient's accounts should be reviewed, and the patient should be informed of any outstanding debt owed. The patient will be given the opportunity to resolve old accounts at the time of service.

Outpatient Services Not Scheduled
When a patient presents for outpatient services that have not been scheduled and pre-registered, the Registrar will request and make a copy of the patient's picture I.D. and any insurance cards provided. If the patient states that they have insurance, the Registrar will verify eligibility via tools provided, and notify the patient of their financial responsibility at the time of service including any co-pays or deductibles owed. In addition, the patient's accounts should be reviewed, and the patient should be informed of any outstanding debt owed. The patient will be given the opportunity to resolve old accounts at the time of service. If the patient states they do not have any insurance, the Registrar will screen the patient for Medicaid eligibility through the Medicaid GAMMIS web portal. A copy of the GAMMIS results will be scanned into the patient's account. If no insurance is found, the patient will be registered with the financial class "Private Pay" and will apply prompt pay discount and attempt to collect the amount due.

Managed Care Agreements:

For patients with insurance, the hospital has specific managed care agreements. The patient's responsibility will be determined by the third-party payer. The dollar amount will be calculated using the contracted rate agreed upon with the payer.

Financial Assistance Policy:

Prior to collection patients without insurance will be notified of the Jefferson Hospital Financial Assistance Policy (FAP) and will be screened for financial assistance eligibility and for Medicaid eligibility according to the terms of the FAP by CRS.

Payment Methods:

Jefferson Hospital will accept the following forms of payments:
Cash
Credit Card – Visa, MasterCard, American Express, Discover
Money Order
Debit Cards with Visa or Mastercard logo
Bank or Personal Check
Care Credit

Payment Agreements:

Based on Jefferson Hospital Financial Payment Agreement can be arranged by the Insurance Biller and approved by the Business Office Director, at the patient's request.

Documentation:

All conversations between Jefferson Hospital staff and patients/guarantors will be documented in the patient's record to include estimated balance owed, patient's willingness to pay, payment methods, refusal to pay, referral Revenue Cycle Manager and any other pertinent collection information.

Private-Pay Discounts:

When a private-pay patient is notified of their financial responsibility for the current visit the discounts will be offered to the patient:

1. Discounts will be offered for accounts paid in full;

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a. 30% for Private Pay accounts paid in full within 30 days and
b. 30% for accounts paid in full within 30 days after insurance pays, if the balance remains unpaid after 30 days, the account will be referred to an early-out vendor for collection.

2. If patient is unable to pay at the time of service, a payment plan can be arranged per the below chart:

Payment Plan Schedule:

Amount Owed:	**Minimum Payment:**	**Maximum Months:**
< $100	Payment in Full	N/A
$101-$500	1/12th of the total	12
$501-$1,000	1/18th of the total	18
$1,001 - $5,000	1/32nd of the total	32
$5,001 - $7,500	1/42nd of the total	42
Over $7,501	To be determined	N/A

3. If the private pay patient is unable to pay at the time of service, they will be referred to CRS and according to the Financial Assistance Policy (FAP) will be screened for financial assistance eligibility and for Medicaid eligibility according to the terms of the FAP.

Reviewed/ Revised		**Revised**						
Date/ Initial	**10/10/18**	**5/2019 CFO**						

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