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 LIPs 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 will 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.

Definition of Terms

Amounts Generally Billed (AGB) – The amount by which charges for U*ninsured* 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 and can be scheduled in advance. Elective services may be for a better quality of life, but are not life-threatening medical conditions. In some cases, it may be for services treating a serious medical condition.

Emergent – Service is needed immediately due to injury or sudden illness. Examples

include difficulty breathing, suspected heart attack, uncontrolled bleeding or possible stroke.

Expected Reimbursement – The estimated collectible amount for services rendered, calculated at the sum of payer-allowed reimbursement under applicable contractual agreements and the patient responsibility, net of all contractual adjustments and known pricing reductions.

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 helping patients apply to programs such as; Marketplace, Medicaid, Cancer State Aid, COBRA, Copay Programs, Foundations, Drug Replacement 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.

Licensed Independent Practitioner (LIP) – Physician or any other individual permitted by law and by the Hospital to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

Prompt-Pay Discount – A 5% discount of the insured patient's 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 an 85% Self-Pay Discount based on the most recent AGB.

STAT – Services ordered by a LIP 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. The condition may be life-threatening. Examples are acute appendicitis and trauma.

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 will be considered medically necessary. These individuals are listed as Medicaid pending, Good Sam, St. Mary's or approved 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 **Billing, Collection and Financial Assistance (Administrative Policy #1220-A)**.

SJ/C **requires** payment of any remaining deductibles, co-pays, and/or co-insurance amounts for any service deemed Elective by the patient's ordering LIP.

For elective surgical services, patients must be financially cleared at time of preregistration or three (3) days prior to service. Accounts are considered financially cleared to proceed once 50% of the expected reimbursement has been satisfied, which includes any combination of insurance preauthorization and patient payments. Any remaining patient balances will be required to be transferred to a payment plan. Patients unwilling to make their deposit and/or establish a payment plan, will be referred back for reschedule until they can be financially cleared.

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.

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 LIPs.

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:

Elective Services

Insured	Uninsured
Minimum of 50% of the expected reimbursement is met with any combination of preauthorization and patient payment. Must be paid three (3) days prior to scheduled service.	Self-pay discount of 85% is available for service(s)
Additional 5% prompt pay discount if all of the patient's responsibility is paid prior to service.	Patients will be screened for Medicaid or other state programs and if determined eligible, they will be considered financially cleared.
If the remaining patient responsibility is not paid, a payment plan must be established for balance before proceeding with scheduled service(s).	If unable to pay in full, a payment plan will be required.

Urgent Services

Insured	Uninsured
Minimum of 50% of the expected reimbursement is met with any combination of preauthorization and patient payment, by time of service.	Self-pay discount of 85% is available for service(s)
Additional 5% prompt pay discount if all of the patient's responsibility is paid prior to service.	No additional discounts
If unable to pay in full, a payment plan will be required.	If unable to pay in full, a payment plan will be required.
A Financial Assistance Application, can be completed. (Form #FN40111 found in the Forms Repository). If approved for financial assistance, the patient will be cleared.	Patients will be screened for Medicaid or other state programs and if determined eligible, they will be considered financially cleared.
	If not eligible for Medicaid or other programs, patients will be provided a Financial Assistance Application (Form #FN40111 found in the Forms Repository). If approved for financial assistance, the patient will be cleared.

For scheduled services, patients with a bad debt history will be required to pay the estimated responsibility in full and prior to service. Additionally, collection attempts will be made on previous accounts in bad debt.

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 if deemed medically necessary, under **Financial Assistance (Administrative Policy #1220-A)**.

B. Scheduled Services

Scheduled services will 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.

For all scheduled services, patients who are uninsured or underinsured will be required to participate in a financial assistance interview/screening. This interview will take place at the point physician referral and prior to treatment. Eligibility for coverage and program assistance will be determined during the financial assistance interview. Patient compliance for enrollment in eligible coverage and program assistance is required (includes providing all required documentation), to be deemed financially cleared for service.

For ongoing treatment programs, prior to patient acceptance into treatment, payment for diagnostic services is required. This payment will be based on the patient's estimate for diagnostic services. A complete treatment estimate will be provided, once the treatment plan is established. Patients who are uninsured or have single coverage (excluding Medicaid) will be required to comply with the financial counseling and clearance process, prior to treatment.

C. Unscheduled Services

Unscheduled services will 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 50% 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: 07/10/2029
Originating Department/Committee: Patient Accounts
Reviewed: 03/17, 07/17, 03/19, 07/24, 06/26
Revised: 03/17, 07/17, 03/19, 07/24, 06/26
Rescinded:
Former Policy Number(s):