



PROCEDURE

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| SPONSOR: Business Office Services | AREA: Business Office Services |
| SUPERCEDES: | DESCRIPTION: Self-Pay Discount Procedure |
| APPROVED: October 1, 2004 | REFERENCE: |
| EFFECTIVE: October 1, 2004 | Page 1 of 5 |

SCOPE: All Triad facilities.

PURPOSE:

To provide procedures for reviewing and processing uninsured (self-pay) accounts that may be eligible for public assistance, financial assistance discounts or self-pay discount whose dates of service are on or after October 1, 2004.

PROCEDURE:

It is the policy of Willamette Valley Medical Center to provide a thorough and efficient method for identifying uninsured patients and determining their eligibility for: Public Assistance Programs, Financial Assistance Discounts or Self-pay Discounts for services received.

| Responsible Party | Action |
|---|---|
| <p>Business Office Director or designee, CFO, Controller, Patient Access Manager</p> | <p>Prior to implementing this policy the following system indicators/values must be present and active in the facilities patient account, general ledger and logging systems:</p> <p><u>Financial Class:</u> A Willamette Valley Medical Center Standard Financial Class has been identified to represent Charity Care. Facility specific Discount amounts will be provided by the Managed Care Department and set to exclude the \$250 OP non-emergency room deductible amount per account.</p> <p><u>Process at the point of Registration/Patient Access for all uninsured patients presenting for service:</u> Patient Access registers patients as self-pay if the patient has no healthcare insurance and receives no benefits through a federally funded healthcare program. Federally funded healthcare programs include Medicare, Medicaid, and CHAMPUS/TriCare.</p> <p>All OP non-emergency room services will be subject to \$250 deductible-first dollar coverage. The facility specific discount will be applied to each OP non emergency room account.</p> <p>Payment for services or a deposit is requested at pre-registration, registration, while in-house and at discharge. Collection expectations should be communicated to the patient/guarantor.</p> <ul style="list-style-type: none"> • Patient is registered following the usual process • Apply the Self Pay Discount Insurance Plan to the account • Apply the facility specific discount to the patient charges. The non-emergency outpatient deductible of \$250 will be considered to |
| <p>Patient Access</p> | |



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- determine the patient portion due
- Receipt is issued and posted to the patients account for monies received
- Present the Patient Contract for signature by the patient or responsible party (Attachment F)
- The account will follow the normal collection process

If the patient is not able to pay for services received or make an adequate deposit, the account will be referred to a government Eligibility Vendor for screening for any available Public Assistance Programs.

Public Assistance Program may include: Medicaid, County Indigent funds, State Indigent Funds, Crime Victims Assistance Program or Indian Health.

Eligibility Vendor process - screening for Public Assistance qualification:

Eligibility Vendor

The Eligibility Vendor representatives will screen all self-pay patients while in-house or following service to determine if the patient meets the eligibility qualification of any existing local, state or federal assistance program. The Eligibility Vendor is responsible for completing and submitting the required forms for any available assistance program. If it is determined that the patient meets or potentially meets the qualifications the facility representative will:

- Place the appropriate Insurance Plan on the account – Medicaid Pending, State/Co Indigent Care Pending or Indian Health Plan Pending (Reference: Medicaid Pending Procedure)
- Monitor the account weekly/monthly to determine when eligibility is finalized (Reference: Third Policy Eligibility Procedure)
- Once the eligibility is completed and an identification number or authorization has been assigned, remove the pending Insurance Plan and assign the appropriate Insurance Plan – Medicaid, State/Co Indigent Care Plan or Indian Health Plan

Once it is determined that the patient does not qualify for any public assistance programs, the designated staff will begin the process of determining the patients qualification for an Indigent Discount.

Process for determining a patients qualification for Indigent Discount:

Financial Counselor

Any patient who is uninsured and has no health insurance, does not qualify for any public assistance programs and is unable to pay for health care services



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will be screened for financial assistance. The Financial Assistance Application will be given to the patient at the point of service or mailed to them upon contact with the business office personnel. Qualifying for Indigent Discounts will be based on the following:

1. Services received after 10/1/04
2. Completion of the Financial Assistance Application (Attachment A).
3. Receipt of the required documentation within 10 business days of receiving the application.
4. Apply the Charity Pending Insurance Plan to the account (Reference: Charity Pending Policy)

Once the required documents have been received and reviewed for completeness, the designated staff member will complete the Financial Assistance Approval Worksheet (Attachment C). The guidelines set forth in the Implementation Instructions for assistance (Attachment E), should be followed as well. The patient should be contacted if any information is missing.

The criteria listed below may be used in lieu of the complete Financial Assistance Application and supporting documentation qualifying the patient for an Indigent Discount:

- Any state / local assistance program with an appropriate verification process to assure indigence.
- Eligibility under the State Food Stamp Program

If it is determined that the patient qualifies for assistance, the manager or designee will run a Credit Bureau or/and a property asset listing if necessary. Proper approval based on hospital specific guidelines should be obtained. (IE. \$25,000.00 or greater must have CFO approval.)

1. Once final determination is made concerning the level of Indigent Discount that the patient is qualified for, the Charity Pending Insurance Plan should be removed and the appropriate Charity Insurance Plan should be applied to the account.
2. Charity adjustment will be automatically calculated and posted to the account based upon the insurance plan assigned.
3. The financial assistance approval letter (Attachment D2) should be sent

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to the patient.

4. Present the Patient Contract for signature by the patient or responsible party (Attachment F)
5. The account will follow the normal collection cycle if there is any patient portion remaining.
6. Copies of all applications and financial assistance worksheets must be maintained as financial records for audit purpose.

If it is evident that patient does not qualify for charity or fails to respond or cooperate with providing the complete required documentation, the designated business office staff will complete the following steps:

1. The Charity Pending Insurance Plan will be removed from the account.
2. The account will be reviewed for application of the facility specific self-pay discount less the non-emergency room outpatient service deductible of \$250.
3. The Self Pay Discount Insurance Plan will be placed on the account.
4. The facility specific self-pay discount will be automatically calculated less any applicable deductible and posted to the account.
5. Present the Patient Contract for signature by the patient or responsible party (Attachment F)
6. The account will follow the normal collection process.
7. Mail letter to the patient informing them of the discount and balance due (Attachment D1)

The facility should display information concerning the availability of Financial Assistance for Uninsured Patients.

1. Signs notifying uninsured patients of Financial Assistance Programs must be prominently posted at all registration points.
2. Standard verbiage will be used as follows:



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Uninsured Patients:

**Ask about
(Insert Hospitals name)
Financial Assistance Programs**

Definitions:

Yearly Income: The sum of the total gross income of the household for the prior 12-month period.

Financially Indigent: An uninsured individual that does not qualify for state or federally funded healthcare programs, whose household yearly Income is less than or equal to 100% of the poverty guidelines.

Medically Indigent: An uninsured individual that does not qualify for state or federally funded healthcare programs, whose income exceeds poverty guidelines and healthcare expenses meet or exceed 25% of total yearly income.

REFERENCE:

Med-Manual, 305. Effect of the Waiver of Liability Provision on Bad Debts; Provider Reimbursement Manual (CMS Pub 15-1)

Med-Manual, 304. Bad Debts Under Medicare; Provider Reimbursement Manual (CMS Pub 15-1)