Conemaugh Health System

Patient Finance Services Policy - Hospital Division

TITLE: Patient Self-Pay Collection Policy

PURPOSE:

Conemaugh Health System's Mission to its patients includes providing assistance to those who ***do not have insurance, or who have a financial responsibility for after-insurance balances***, do not qualify for Medical Assistance or Charity Care, but for whom the financial costs of care received creates a significant burden. This policy establishes the procedures for these situations.

In assisting those persons who do not qualify for Medical Assistance or Charity Care and who do not have insurance or who have a financial responsibility for after-insurance balances, Conemaugh Health System is committed to respecting the dignity of persons and reflecting responsible stewardship.

POLICY:

1. Patients without insurance will be provided medically necessary services regardless of their ability to pay.
2. Self pay inpatients, scheduled outpatients, and emergency patients will be screened by Revenue Cycle representatives or agencies for Medical Assistance eligibility, other governmental assistance programs, and/or charity care.
3. Patients without supplemental insurance may be screened by the Medical Assistance Eligibility Vendor for potential SSI and/or supplemental Medical Assistance.
4. Third party deductible, coinsurances and copay amounts are the responsibility of the patient and, when they can be accurately determined, are due at the time of service. **Emergency room patients shall be requested to pay co-pay amounts at the time of discharge.**
5. **Emergency Medical Care: Emergency care will be provided regardless of the patient's ability to pay or financial assistance status, according to EMTALA Guidelines.**
6. Acceptable methods of payment are cash, personal check, money order, Visa, MasterCard, and Discover.

PROCEDURES:

A. <u>Payment Prior to or at the time of service:</u>

Non-emergency Services: Patients with insurance

1. At the time of registration or pre-registration, the patient's insurance will be verified using all available methods of verification.
2. The response from these systems may indicate the policy copayment, deductible, and/or coinsurance amount for which the patient is liable.
3. When the copayment, deductible, and/or coinsurance amount can be accurately determined, the payment of that amount shall be requested. Payment may be made by credit card, personal check, or cash.
4. Patients with verifiable insurance coverage who cannot, or will not, pay the requested amount will be invoiced for patient liability amounts after insurance payment(s) have been received. Exceptions to this provision are patients who are scheduled for cosmetic, bariatric, and dental procedures. Out of pocket payments are to be made prior to service being rendered.

Non-emergency Services: Patients without insurance

1. Medicaid eligibility will be checked for any patient with no third party coverage. If eligibility is located the appropriate Medicaid plan will be entered into the system.
2. Scheduled patients with no insurance coverage will be referred to the Financial Counselor who will screen for potential eligibility for governmental assistance. Patients who are potentially eligible will be referred to the Medical Assistance Eligibility Vendor for further assistance in applying for these programs.
3. Patients not meeting the screening criteria for Medicaid will be screened for Charity Care (see Charity Care policy and procedure).
4. Deposits equal to 40% of the average charge for most elective services will be requested from all scheduled patients. For cosmetic, bariatric, dental, and tubal reversals, the deposit requirement will be 100% of the established fee price.

Emergency Services: Patients with insurance

1. At the time of emergency department registration, the patient's insurance will be verified using all available methods of verification.
2. If deductible, coinsurance, or copay amounts are due, the patient will be advised to stop at the registration/discharge desk at the conclusion of service to make payment.

Emergency Services: Patients without insurance.

1. Patients with no insurance will be checked for Medicaid eligibility. If eligibility is located, the appropriate Medicaid plan will be entered into the system.
2. If no third party coverage is available, the patient will be requested to pay a minimum payment of $100.00 upon discharge. In consideration of the EMTALA regulations, **under no circumstances is the patient to be asked for payment prior to service.**

B. Post service billing and payment

1. Patients will be invoiced for any amounts not paid by insurance after their claims have been adjudicated by their insurance carrier. Patients without insurance will be invoiced within 5 days of service.
2. The patient statement cycle begins with an itemized detail summary of charges by service area. If no payment is made, the "first patient statement" is issued in 30 days. Additional patient statements will be issued at the 60th day and again on the 90th day.

   If the patient balance remains after the 90th day statement, a message on the statement will indicate the final notice for payment or payment arrangements before being sent to a collection agency. If there is no payment or payment arrangements established, the account will be transferred to bad debt (collection agency) at the end of the 120 day cycle. All accounts will be screened for presumptive charity care (as per the Charity Care Policy) prior to being sent to collections. If the account is placed with the collection agency, the Credit Bureau will also be notified of the delinquency. Potential liens, lawsuits are also avenues that may result in non-payment of an account.

C. Self Pay Discount

For patients who have no insurance coverage, patient balances will be discounted by 60% off of charges. There will be no discounting for any after insurance balances (i.e. copayments, deductibles, coinsurance) as mandated by Pennsylvania State Insurance Law.

D. Payment Plans

Patients unable to pay their balance due in full may make payment arrangements for up to 12 months, however, the minimum monthly payment will be $25 or 1/12th of the balance, whichever is higher.