Rice Memorial Hospital

PATIENT ACCESS PROCEDURES

I. PURPOSE: To ensure that all Patient Access functions (Scheduling, Patient Information Collection, Insurance Verification, Authorization, Financial Clearance, POS Collections, Registration, and Financial Counseling) are executed consistently and proficiently according to the protocol and timeframes outlined in these procedures.

II. POLICY: It is the policy of Rice Memorial Hospital to implement Patient Access procedures that will provide a positive patient experience and gather pertinent patient and insurance information vital to downstream processes and reimbursement. Employees of Rice Memorial Hospital are strictly forbidden from displaying behavior that is abusive, harassing, oppressive, false, deceptive or misleading to the patient or any other customer.

III. RESPONSIBILITY: Revenue Cycle - CEO and Board

IV. SCHEDULING ELECTIVE PATIENTS

A. All elective treatment or procedures should be scheduled fourteen or more days (two weeks) in advance of service unless Ordering Physician dictates otherwise (to allow ample time to complete insurance verification and authorization obtainment procedures)

B. All authorizations for non-emergent or elective procedures should be obtained three or more days in advance of service. Patient Access staff must obtain this authorization from the appropriate clinical area.

C. When attempting to delay service, the Ordering Physician has final say in the matter as to the urgency/emergency of treating the patient.

D. The obligation for payment for healthcare services becomes effective when services are scheduled. It is the responsibility of Pre-Registration staff to check to see that all patients scheduled for treatment do not possess outstanding bad debt with RMH (patients with bad debt are to be referred to Financial Counseling). All patients receiving treatment at Rice Memorial Hospital are responsible for payment for services in accordance with Rice Memorial Hospital's policy:

1. All identified patient responsibility (co-pay, deductible, co-insurance, deposit, outstanding balances, etc.) will be collected pursuant to accepted protocols to include prior to service, at the time of service, and at discharge.

    a. Scheduled patients: Pre-Registration staff should run eligibility and benefits queries prior to service to ensure the patient has active coverage(s). Staff should also document all patient responsibility (co-pay, deductible, co-insurance, deposit, outstanding balances, etc.) that is identified by these queries and by looking at previous accounts for that patient/guarantor. Documentation should be made in an account note within the patient encounter to help facilitate POS Collections

requests during Pre-Registration and Registration processes.

b. Scheduled patients: Pre-Registration staff must place at least one contact attempt to the patient/guarantor regarding their patient responsibility prior to service. For patients scheduled more than seven days in advance of service, a minimum of two contact attempts to the patient/guarantor must be made. All contact attempts should be documented in an account note within the patient accounting system.

c. Add-on patients: Pre-Registration staff are required to conduct the Pre-Registration activities mentioned above immediately (within one hour) of the patient visit being scheduled

d. Registration: Staff should request POS payments from all patients/guarantors that have a patient liability at time of service (whether scheduled or unscheduled), and an account note should be made to indicate that a collection attempt was made.

(i) For ED Patients: POS payments should be requested in accordance with EMTALA, and can only be made after the patient has been triaged and stabilized.

E. Self-Pay Patient Responsibility– If the patient owes less than $500, a minimum of $250 must be paid at or before the time of service and the remaining amount must be paid within two months. If the patient owes $500-$2,500, the patient must pay at least $500 prior to or at the time of service, with the remaining to be paid via EFT within six months.

a. This policy applies to both true Self-Pay patients and patients with Residual Self-Pay obligations after Insurance has paid. *Please note that if the patient qualifies for UD or grants, the amount paid through these programs should be applied first. The patient/guarantor will be held to the Self-Pay policy above based on the remaining amount owed.

F. Patients with Bad Debt Balances – Patients with balances in Bad Debt must pay all monies owed prior to receiving services (unless patient presents for Emergency services). However, the Ordering Physician has final say in the matter as to the urgency/emergency of treating the patient.

V. FINANCIAL CLEARANCE

A. Policy

1. Rice Memorial Hospital's policy is to ensure that all non-emergent/urgent admissions and procedures have been screened and authorized by the payer and service area prior to services being provided, and that payment arrangements have been made by the patient for the patient liability portion of services and any outstanding balances or bad debt (within the last 24 months) that the patient may have. This policy also extends to the need to provide for financial clearance for those patients who are uninsured.
2. Failure to provide for appropriate authorization and/or financial clearance will cause the organization to delay services until authorization and/or financial clearance has been obtained. Rice Memorial Hospital will make sure that those patients who are uninsured and/or underinsured are evaluated in terms of their ability to pay and the best way to clear the account (typically called "financial clearance"). This policy covers all patients who access the organization from any entry point. It is the goal of Rice Memorial Hospital to establish financial clearance processes and to improve the patient's financial experience. In general, applicable Patient Financial Services Management shall coordinate activities

with other functional areas involved in the financial clearance process whenever possible. As with point of service collections, all activity associated with the Financial Clearance Policy is subject to adherence to the rules and regulations of EMTALA and HIPAA.

B. Descriptions:

1. Authorization: A health plan's system of approving payment of benefits for services that satisfy the plan's requirements for coverage.
2. Pre-Certification: Typically, a requirement that a plan member or the physician in charge of the member's care notify the health plan and gain approval, in advance, of plans for a patient to undergo a course of care, such as a hospital admission or complex diagnostic test.
3. Medical Necessity: Services or supplies which meet the following criteria:
    a. They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition;
    b. They are provided for the diagnosis or direct care and treatment of the medical condition;
    c. They meet the standards of good medical practice within the medical community in the service area;
    d. They are not primarily for the convenience of the plan member or a plan provider;
    e. They are the most appropriate level or supply of service, which can safely be provided.
4. Uninsured: An individual who does not have “coverage” related to payment for their hospital/healthcare expense through a non-governmental third-party commercial and/or managed care payer, or through a government-sponsored payer such as Medicare or Medicaid.
5. Financial Clearance: Patients who have met the following criteria are considered financially cleared:
    a. Insurance benefits have been verified for active coverage on the date(s) of service and pre-certifications/authorizations have been obtained or acceptable payment arrangements have been made for any identified patient liabilities. Also, all necessary demographic and insurance information has been provided to facilitate billing and reporting requirements, and outstanding balances have been reviewed.
    b. The patient may qualify for assistance through Medicaid or other funding sources as identified by the Financial Advocate and as supported by applicable tools. The patient is compliant with information required of said programs.
    c. Valid signatures are on file for all documents as appropriate, including but not limited to: patient financial responsibility, Medicare Secondary Payer Questionnaire (MSPQ), Assignment of Benefits (AOB) form, Release of Information (ROI). *MSPQ questionnaire must be completed for all Medicare patients.
    d. Rice Memorial Hospital will ensure that full communication of expectations occurs at the earliest possible/compliant point within the patient’s care/service pathway.
6. Elective: Term used to describe patients who do not require immediate medical attention and have the ability to choose whether or not to undergo a procedure or receive treatment.

7. Urgent: Term used to describe the condition of a patient requiring admission to the hospital for a clinical condition that would require admission for diagnosis and treatment within 48 hours; otherwise the patient's life or well-being could be threatened.
8. Emergent: Term used to describe a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
    a. Serious impairment to bodily functions, or
    b. Serious dysfunction of any bodily organ or part.

C. Timeframes:
    a. Normal Business Hours (Monday – Thursday: 7:30am – 5:00pm; Friday: 8:00am-4:30pm): The financial clearance process is initiated and completed immediately upon notification that Pre-Registration (Scheduled patients) or Registration (Unscheduled patients) processes have been completed for the patient.
    b. Outside Normal Business Hours: The financial clearance process is completed on the following business day.

VI. REGISTRATION

A. Policy
1. Priorities of admissions are directly related to the degree of medical emergency of the patient's condition. Patients will be admitted promptly upon verification of the medical need, or emergency admissions through the emergency department at Rice Memorial Hospital. In no event will a patient be denied treatment in the Emergency Department because of financial issues; this policy is in full compliance with the rules and regulations of EMTALA.
2. All inpatients and in-scope outpatients will be financially cleared prior to discharge. Financial Counselors will be responsible for ensuring that procedures are in place to financially clear patients prior to discharge.

B. Pre-Admissions or Direct Admits
1. Accurately collect appropriate patient information for admission, care delivery, billing and collecting processes at time of Pre-Registration or Registration.
2. Verify patient insurance coverage and document an account note of where/how coverage was verified. Identify and attempt to collect any co-pays, deductibles, deposits, and other patient responsibilities due. An account note should be documented on the account indicating total patient responsibility and that staff requested patient payment at time of Registration. Patient coverage and responsibility is identified via:
    a. Patient/Guarantor insurance card
    b. Eligibility & Benefits query
    c. Payor website

    Coverage should be verified at the beginning of ever new calendar month for all coverage.
3. Scan the front and back of the patient's insurance card into the patient accounting system. Medicaid insurance cards should be collected and scanned every 30 days, and insurance cards for all other payers should be collected and scanned every 120 days. If a patient does not have their insurance card with them, enter a note in patient notes to indicate this.

VII. Distribution: Business Office, Patient Access Staff

VIII. Keywords: Patient Access, Registration, Financial Counseling