UNIVERSITY HOSPITAL McDUFFIE
Thomson, Georgia

Policy No. 8310-125
Approval ________
Effective 1/13
Reviewed 4/14, 12/15
Revised 1/17

POLICY TITLE: **MINIMUM INITIAL PAYMENT AND ESTABLISHING A PATIENT ON A PAYMENT PLAN**

POLICY PURPOSE: To cost effectively achieve payment for services rendered while facilitating access to care and actions upon non-payment.

POLICY

University Hospital McDuffie (UHM) permits installment payment without security, interest, or service charge. These payment plans assist the patient in their financial planning and minimize any *inconvenience* associated with arranging payment terms prior to receiving services at UHM. UHM willingly complies with the Emergency Medical Treatment and Labor Act (EMTALA). Requests for payment in the Emergency Department shall not be made before completion of a medical screening examination and any subsequent request shall not delay stabilizing treatment for any emergency condition or labor.

PROCEDURE

A. The Registrar will prepare an estimate of the charges and patient liability for the service for which the patient is scheduled. Each ancillary service area will estimate charges for which the patient will be responsible.

B. External and patient requests for estimated charges should be prepared in accordance with Hospital Policy 8310-126.

C. Except in the ED, the Registrar requests a minimum payment at or prior to registration.

The “Minimum Payment Information” notice is mailed or communicated via telephone as part of all preregistration packages and given to patients at registration by the Registrar.

Minimum payments at registration are as follows:

1. ELECTIVE SERVICES- Require payment in full for all elective services when the patient has prior outstanding self-pay balance(s). Patients in good financial standing may pay fifty percent of quoted procedure charge and elect a minimum

payment plan for the unpaid balance. An elective service is a service not covered by his/her insurance plan or, if the patient is uninsured, would not be covered by Georgia Medicaid if applicable. The Registration Manager or designee may approve a minimum payment plan of up to 10 months to payout or $100.00 per month, whichever is greater.

2. For Medically Necessary Tests & Procedures (as defined in the Georgia Medicaid Policies & Procedures)--Request payment of all co-payments and deductibles**.**.
   a. If the patient liability for a Medically Necessary Test(s) or Procedure(s) is greater than $100.00, request 10% of the amount, but not less than $100.00, at registration. See D below with respect to payment plans for the balance.

3. A patient who presents to register for a non-emergent Medically Necessary Test(s) or Procedure(s) and is unable to make the requested minimum payment will be asked to complete an initial application for indigent/charity care. The Registrar checks the patient's current bad debt with UHM. To check bad debt, assess all accounts in the patient's name and check for any remaining balances. A patient with bad debt must pay the lesser of the full amount of the charges or at least $100.00 and establish a payment plan in accordance with D below. All other applicants must make the co-payment applicable to individuals with incomes below 200% of the Federal Poverty Guidelines or registration will not proceed. (Refer to Indigent/Charity Care Hospital Policy 8310-123).

4. In the event a patient is not eligible for registration due to refusal to make a required minimum payment amount, to complete an indigent/charity application, or the service being elective (see C.1 above), call the patient's physician and inform him/her or the physician's office that the patient has refused to make a minimum required registration payment and/or complete an indigent/charity application.
   a. If the physician requires the service to be completed, the physician must certify that the service is an EMERGENCY SERVICE. If the physician states the service is an emergency service, register the patient and notify the Registration Manager or designee. The patient will be registered as Self Pay.

      b. If the physician does not certify the service as emergency, cannot be reached, or does not indicate whether the service is emergency or not, advise the patient to contact his/her physician.

5. UHM offers self-pay Patients a "Self-pay Discount" which is determined as the unweighted average discounted percentage negotiated by the hospital managed care companies from the prior year plus Medicare payment. The "Self-Pay Discount" will be updated annually on April 1st each year.

a. Excluded will be any Self-Pay amounts prorated on Insurance Financial Classes since waiving Co-Pay, Deductible or Carve-out amounts would be looked upon by most PPO/HMO Contracts as encouraging services. Medicare plus Medicaid are excluded per State & Federal regulations.

6. In accordance with the HIPAA Privacy Rule requirements and Procedures, UHM agrees to allow patients the right to elect not to have their services billed to their insurance plan. If a patient chooses not to allow the hospital to submit patient's claim(s) to the health plan then:

a. Patient does not qualify for any for ICCP program (See Hospital Policy 8310-123)

b. Patients will qualify for the Self-pay discount as described in the above paragraph.

c. Patients are not eligible for payment plan

d. Patients must pay the estimated charges less Self-pay Discount for services to be received prior to the service being rendered. After procedure completed, patient will be balanced bill for any discrepancy between actual charges and estimated charges (Self-pay Discount will also apply to the additional charges)----patient must pay this amount in 10 days after billing date. If patient does not pay balance with in 10 days, Hospital reserves the right to bill insurance plan for balance and patient will forgo any future consideration to elect not to bill Health plan.

D. In the event the estimated patient liability for a non-elective service exceeds $100.00 and the patient desires to make installment payments, the Registrar establishes a minimum payment plan for the balance of patient liability.

E. Patients given indigent/charity care declaration/applications will also be given the Requirements Checklist by the Registrar. The application must be completed at the time of registration. This policy (8310-125) will apply until the patient has been certified or denied in the UHS (UHM) Indigent/Charity Care Program. At that time, the Financial Class will be changed and Hospital Policy 8310-123 or this policy, 8310-125, respectively, will be applied.

F. For ED patients, the Registrar will provide the patient the "Minimum Payment Information" notice if requested.

G. For outpatient services/admission, the Registrar will request the minimum payment. The patient must be told that admission will not be denied nor the quality of service affected by a failure to make the minimum payment.

NOTICE TO OUR PATIENTS

IN AN EFFORT TO CONTINUE PROVIDING COMPETITIVELY PRICED QUALITY HEALTH CARE TO OUR PATIENTS, UNIVERSITY HOSPITAL McDUFFIE HAS INSTITUTED INTEREST FREE TEN MONTH MINIMUM PAYMENT PLANS. WHILE NO PAYMENT IS REQUIRED PRIOR TO EMERGENCY DEPARTMENT SERVICES, A MINIMUM PAYMENT IS REQUIRED FOR PARTICIPATION IN INSTALLMENT PAYMENT PLANS.

MINIMUM PAYMENT PLAN ("MPP") TERMS

GUARANTOR BALANCE MINIMUM PAYMENT OF TOTAL CHARGES

- Patient liability $0 - $100:
  Pay 100.00% at time of service registration.

- Patient liability $101 - $1,100:
  Pay $100 at time of service registration and the remainder in monthly payments of $100 except the last payment, which will vary from $1 to $99 depending upon the actual charge. The installment payments are due on the first day of each calendar month commencing the first month beginning after the date of service (discharge).

- Patient liability greater than $1,101:
  Pay $100 at time of service and the remainder in monthly payments equal to one-thirtieth (1/30) of the balance provided that in the event the monthly payment would exceed $200 per month, the payment period will be extended to cause the monthly payment to be approximately $200 per month. The installment payments are due on the first day of each calendar month commencing the first month beginning after the date of service (discharge).

H. ACTIONS FOR NON-PAYMENT:

1. Account balances should receive a minimum of three (3) statements, in 30 day intervals and 2 phone calls. (EXCEPTIONS: mail returns, with no successful resolutions; accounts not responsive to billing attempts/phone calls with previous bad debt history, accounts qualifying for indigent write-off).

2. At 90-120 days from date of service, a decision will be made to continue follow up attempts or referral to bad debt collections, indigent/charity review. (EXCEPTION: Medicare recoverable account balances will need to be billed a minimum of 4 statements, 120 days, from 1st billing statement, prior to bad debt referral).

3. All attempts should be made to request payment in full once contact with patient is established. In the event payment in full is not possible a payment schedule in keeping with Minimum Payment policy 8310-125 should be pursued. Payment arrangements below the standards set in 8310-125, will be considered on an as needed basis.

4. Patients alleging financial hardship will be asked to complete a Financial Application Review form for payment reduction, charity/indigent review.

5. Use of various data bases/tools, i.e. , Hospital billing system, Bad Debt Collections system, Credit Bureau, Self Pay Compass will be used in the course of follow- up to determine/support collectability; bad debt referral; charity/indigent decisions.

6. Patient liability balances presenting on daily reports will be worked, via alpha split designation.

7. All accounts of the patient/guarantor, not only the account presenting on the daily report, will be considered for potential collections/ bad debt referral/indigent review.

8. Accounts presenting for Bad debt collections shall receive written correspondence outlining the account balance, and soliciting payment of balance.

9. Accounts not paid with initial contact correspondence will move to a Collector work drive for follow up.

10. The Collector will review the account and access for payment potential. Calls will be made to all contact numbers, and payment solicitation will be made.

11. Payment plans in keeping with Hospital Policy 8310-125 will be established when payment in full of account balance is not possible.

12. Accounts not keeping payment arrangements will be reviewed for possible litigation.

13. Accounts that do not meet litigation protocol, i.e. employment, net income, will be referred to an outside Third Party Collections Agent, or area Credit Bureaus as deemed appropriate.