Professional, Employee, Self-Pay, and Charity Discounts – NMOSC Facility only	Subject	PAS
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	USPI Forms	Yes

Section A: Purpose

To ensure that discounts are not perceived as inducements to physicians or as insurance fraud, facilities need to be consistent in offering and applying discounts to the facility's standard fees.

Section B: Policy

It is the policy of New Mexico Orthopaedic Surgery Center (NMOSC) to ensure that:

1. Professional discounts are applied consistently.

2. Employee discounts are applied consistently.

3. Self-pay or cash discounts are granted in accordance with state laws.

4. Charity care is provided in accordance with federal, state and local laws, is applied consistently and equitably, and does not act as an inducement to physicians. NMOSC provides medically necessary care free or at a discount if a patient is unable to pay.

Section C: Persons Affected

Anyone involved in verifying, billing, and collecting cases that are granted a discount.

Section D: Responsibilities

1. New Mexico Orthopaedic Surgery Center (NMOSC) center must abide by the Presbyterian Healthcare System (PHS) established standard discounts for professional, health system-partner employee, self-pay/cash, and charity care cases.

2. The business office manager is responsible for implementation and administration of these policies.

3. The insurance verifier is responsible for obtaining financial information and completed financial assistance forms.

4. The charge processor is responsible for entering all charges and then making adjustments to the patient's account in accordance with the approved agreement with the patient.

5. Facility Management will ensure a notice regarding the availability of financial assistance is posted and clearly visible for patients in any admitting area, business office, or emergency department.

6. Facility Management will ensure their websites include a link to financial assistance and a phone number for patients to call to request assistance or information regarding the financial assistance policy of the center.

7. Facility Management will ensure all patient statements include a summary of the Financial Assistance Program and a phone number for inquiries.

Section E: Definitions

Charity care patient is a patient who is provided a discount as a result of financial need.

FAP – Financial Assistance Policy.

Federal health care program: means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including but not limited to: Medicare, Medicaid/MediCal, managed Medicare/Medicaid/MediCal, Tricare/VA/CHAMPUS, SCHIP, Indian Health Services, Health Services for Peace Corp Volunteers, Federal Employees Health Benefit Plan, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, Pre-Existing Condition Insurance Plans (PCIPs) and Section 1011 Requests.

Financially Indigent means an uninsured or underinsured patient whose total Reported Income is less than or equal to 200% of the **Federal Poverty Guidelines (FPG)**. These Financially Indigent patients are eligible for a 100% discount.

Medically Indigent is a patient whose medical or hospital bills after payment by all third parties exceed a specified percentage of their total Reported Income (ranging from 5%-10%) and who is unable to pay the remaining bill.

Self-pay patient is a patient who does not have or is choosing not to use a third party payor. If the patient has a policy that the center is contracted with then the center must process the claim according to the contract provisions. A patient may be considered self-pay, if the insurance company does not cover the procedure.

Section F: Connections

Part 1: Areas of Exposure

Discounts and professional courtesies are not administered consistently.

Part 2: Key Controls

1. Administrators or CFOs approve all discounts

Part 3: USPI's EDGE™ Connection

Getting paid fully and timely for services rendered

Part 4: Other Policies and Procedures

PAS 9.2.1 NM Collecting from Guarantors

Part 5: Forms

Appendix A - Application for Financial Assistance

Section G: Procedures

Part 1: Professional Courtesy Discounts

1. Per PHS guidelines, NMOSC will not grant professional courtesy discounts to the physician or to his immediate family (spouse, children) and parents. This applies to NMOSC and partner health system physicians.

Part 2: Employee Courtesy Discounts

1. Each USPI facility grants all benefit eligible full-time and part-time USPI employees and their immediate family (spouse and eligible dependents) a courtesy discount equal to 100% of the patient's responsibility for all medically necessary services provided that the individual receiving care has either USPI or some other form of health care coverage. Exceptions:
   If the individual receiving care participates in USPI's Consumer Driven Health Plan, this Plan prohibits the waiver of the individual's deductible amounts, but does allow for the waiver of coinsurance.

If the individual receiving care participates in a government sponsored health plan such as Medicare or Tricare, then we are prohibited from waiving patient financial responsibilities.
The courtesy discount does not include cosmetic surgery.

2. Courtesy discounts will not be granted to partner health system employees.

Part 3: Cash, Self-Pay, and Pre-Bad Debt Settlement Discount

1. Self-Pay Discount

   NMOSC may grant a discount to self-pay patients in accordance with PHS policy. If a self-pay discount is granted, all of the following rules must apply:

   a. For NMOSC, the amount of discount is 30% of billed charges. There is no multiple procedure discount for cases with more than one procedure. All implants will be billed using the facility's normal markup percentages.

   b. This discount may not be combined with any other discount, including Charity care or prompt pay.

   c. The discount must be made available to all self-pay patients and must be consistently applied.

   d. The discount must be applied to the final billed charges, after all procedures and implants have been billed.

   e. During the call about estimated charges, the insurance verifier will inform the patient of any restrictions on personal checks or payment-in–full requirements, in accordance with the facility's financial policy.

   f. If the patient informs the facility after the surgery has been performed that a third party insurance payor will be utilized, the BOM may release information, in accordance with the facility's privacy policy, to the patient so that he may file with his insurance company. The following information should be provided in letter format: date of service; procedure codes and description of services performed; any diagnosis codes and the amount the patient paid for the services. Do not give the patient facility charges or the information on a claim form. The hospital will not submit a claim to a third-party payor for a case performed as self-pay.

   g. Cosmetic procedures may be established by the facility and must be applied to all applicable cases consistently.

2. Pre-Bad Debt Settlement Discount

    a. NMOSC may waive or reduce a patient's coinsurance or deductible amounts, including Federal health care programs, for outpatient services in order to provide a legitimate payment incentive, and in order to avoid collection costs. To qualify for a pre-bad debt settlement discount, the following requirements must be met:

        i. The waiver or discount is not offered as part of any advertisement or solicitation.

        ii. Patients and their representatives may only be informed of the discount's availability during the course of the actual billing process and after date of discharge, and just prior to the account being sent to collections.

        iii. The amount of fees discounted to patients under the pre-bad debt settlement discount must bear a reasonable relationship to the avoided collection costs. The discounted amount must be paid in full within a maximum of 30 days from when the discount was offered.

        iv. The ASC must not later claim the amount reduced or waived as a bad debt for payment purposes under any Federal health care program or otherwise shift the burden of the reduction or waiver onto any Federal health care program, a State health care program, other payers, or individuals.

Part 4: Charity Care Discount

1. Facility is required to grant the discount to a charity care patient determined by NMOSC and Presbyterian Health Services healthcare partner (PHS). The administrator or CFO is to adhere to the charity care policy that is in accordance with those rules and can be applied consistently and equitably. PHS and NMOSC may work together to complete the Financial Assistance process.

    a. Application – Facility will request each patient applying for financial assistance complete a Financial Assistance application form. Applications, along with a copy of this policy and a plain language summary of this policy, may be obtained in the following ways:
        i. Online at http://www.nmscortho.com/.
        ii. By contacting a customer service representative at (505) 291-2300.

iii. By mail, free of charge, upon request to a customer service representative.

b. Calculation of immediate family members – Facility will include patient, spouse, and any dependents. If patient is a minor, facility will include patient, mother, father, and any dependents of mother and father per IRS code.

c. Eligibility – Facility will consider financial assistance for those individuals who are uninsured, underinsured, ineligible for government programs that would pay for services, or otherwise unable to pay for their care. The term "underinsured" includes individuals enrolled in health insurance who are unable to pay for out-of-pocket expenses and fall below 400% of the federal poverty guidelines.
    i. The granting of financial assistance will be based on an individualized determination of financial need, in accordance with this policy, and will not take into account age, gender, race, color, national origin, religion, social or immigrant status, sex, sexual orientation, gender identity, spousal affiliation, or physician or mental handicap.
    ii. Funding will be sought from potential third-party payers, including government programs, before providing financial assistance under this policy.

d. Guidelines – Facility uses the Federal Poverty Guidelines (FPG), in effect at the time the application is reviewed, to determine eligibility for financial assistance. Criteria:
    i. Patients whose family income is at or below 200% of the FPG are eligible to receive medically necessary services at no charge
    ii. Patients whose family income is above 200% but not more than 400% of the FPG are eligible to receive a discount for medically necessary services as outlined in the table below:

Gross Wages and Assets as % of Federal Poverty Guidelines	Patient Responsibility (% of Gross Charges)
200% or less	0%
201% to 250%	25%
251% to 400%	50%
401% or greater	100%

    iii. Amounts charged to patients who are eligible for assistance will be limited to the lesser of the Medicare allowable amount or the sliding scale above.
    iv. Patients who do not qualify for financial assistance may request a special case review based on their individual circumstances. Patients who seek a special case review must complete all documentation and provided the following:

1. Minimum of three most recent bank statements for savings and checking accounts
2. All outstanding credit card statements
3. Documentation of other assets and debt

v. Non-emergent services may be scheduled prior to making a request for financial assistance; however, a determination on the financial assistance application is generally required prior to obtaining services; however, may be made at any point in the collection cycle. The need for financial assistance will be re-evaluated at the beginning of each year and at any time additional information relevant to the eligibility of the patient for financial assistance becomes known Financial assistance will be applied at approved levels to outstanding accounts without respect to date of service.

e. Determination of financial need – Financial need will be determined in accordance with procedures that involve an individual assessment of financial need. These procedures include a process in which the patient or the patient's guarantor is required to complete a financial assistance application and supply personal, financial and other information and documentation relevant to verifying family income and making a determination of financial need.
   i. Documentation requirements include:
      1. Completed financial assistance application
      2. Prior year's tax return(s)
      3. Minimum of two most recent pay stubs
   ii. NMOSC retains the right to accept equivalent or substitute documentation for any of the items listed above on an individual basis.
   iii. NMOSC may explore appropriate alternative sources of payment and coverage from public and private payment programs, and assist patients in applying for such programs.
   iv. When documentation is unavailable, circumstances may justify financial assistance, i.e. enrollment in state funded programs or patient is homeless. Facility will require that a reasonable explanation be provided of why the patient/responsible party is unable to provide the requested verification.
   v. Expired patients – No income verification is required, however, a facility may request documentation of estate assets.
f. If financial assistance is denied, the individual will need to pay for his or her care.
g. All completed information (application, calculation, approval) must be sent to NMOSC; Fax to (505) 213-0339.
h. All financial information provided by individuals to NMOSC or PHS through the financial assistance application process will remain confidential and will only be used for internal purposes. It will not be used for any other purpose.

i. Requests for financial assistance shall be processed promptly; NMOSC will notify the patient or applicant promptly of any information needed to complete an application that has been submitted and will notify the patient or applicant in writing of its decision within 30 days of receipt of a completed application. NMOSC will expedite the review of applications submitted prior to the receipt of services.

2. Basis for Calculating Amounts Charged to Patients - Following a determination of eligibility under this Financial Assistance Policy, a patient eligible for financial assistance will not be charged more for medically necessary care than the amounts generally billed to individuals who have insurance covering such care (AGB). NMOSC uses the Prospective Medicare Method to determine AGB, by using the billing and coding process it would use if the individual were a Medicare fee-for-service beneficiary and setting AGB for the care at the amount it determines Medicare and the Medicare beneficiary together would be expected to pay for the care. NMOSC does not bill or expect payment of gross/total charges from individuals who qualify for financial assistance under this Financial Assistance Policy.

3. The charge processor enters the charges into the PAS and then uses the appropriate journal code to write-off the amount at the agreed upon percentage. The amount written off does not qualify for recognition as receivables or revenue in financial statements, since payment on that amount is never expected.

4. Charity care may be determined after the day of surgery, up to 240 days from the first post-discharge statement, for all balances in existence at the time the application is signed and approved. Future dates of service are not covered by an existing application. Patients may reapply for financial assistance related to any new balances.

5. Actions Taken in the Event of Non-payment. The actions that NMOSC may take in the event of nonpayment are described in a separate Collections Policy. Members of the public may obtain a free copy of this separate policy by contacting a customer service representative or by mail (free of charge) upon request, by using the contact information provided in this policy.

Part 6: Sanctions

Penalties for violation of this policy will vary depending on the nature and severity of the violation. Individuals who violate the above will be subject to disciplinary action up to and including termination; legal action by USPI, including but not limited to, criminal prosecution under appropriate state and federal laws; and providing restitution for improper use.

Part 7: Audit

The Business Office Manager and the Internal Auditor review the adjustments made to the patient accounts based on discount.

Section H: Revision History

Revision Date	Revision Number	Change	Revised Sections
02/01/2020	1.0	New document	N/A

Appendix A
Financial Assistance Application

Financial Assistance Application

If you need help to complete this form, please ask to speak with one of business office representatives or call (505) 291-2300.

Name of PHS Facility___NMOSC_____ Patient Name_____ Account Number_____

Instructions for completing this form:
This completed form should be attached to the required documentation and returned to NMOSC Patient Accounting to be processed.

- Prior year's tax return(s)
- Minimum of two most recent pay stubs

Responsible Party Name_____ Social Security #_____ Date of Birth_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Employer_____ Work Phone_____

Other Responsible Party Name_____ Last 4 digits of Social Security #_____ Date of Birth_____

Cell Phone_____ Relationship to patient_____

Employer_____ Work Phone_____

Gross monthly/annual income $_____

Additional Household Members

Name	DOB	Relationship	Name	DOB	Relationship

Persons who apply for financial assistance are required to first explore other sources of funding. Please indicate which sources you have applied for and the reasons you are not eligible for this assistance.

❑ Group health insurance _____
Does your employer offer group health insurance yes/no?
❑ Medicaid- if denied, please attach a copy of the Medicaid denial
❑ Other state or county assistance (Sole Community, Indigent)
❑ Other third-party programs (homeowners, auto etc.)
❑ Cobra Coverage

Describe inability to pay account balance: (additional documentation may be required)

_____

_____

_____

_____

_____

_____

If you do not have the required documentation listed, please inquire as we may be able to accept alternative documentation to satisfy this requirement. Patients who fail to follow through in the application process, or who refuse to apply for outside programs and who potentially may have qualified, may be denied financial assistance.

I hereby state that the information given herein is true and correct. I authorize any required verification, including credit bureau report. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance does not pertain to other healthcare providers.

Please return completed application and required documentation to the below address or you can fax it to (505) 213-0339:

NEW MEXICO ORTHOPAEDIC SURGERY CENTER
8300 CONSTITUTION AVE NE
ALBUQUERQUE, NM 871107613

Applicant Signature_____ Date_____

NMOSC and PHS are committed to protecting the confidentiality of its patients. Any information provided by individuals to NMOSC and PHS through the financial assistance application process will remain confidential, will only be used by NMOSC and PHS for its internal purposes, and will not be released to any third parties outside of NMOSC and PHS without the express consent of the individual.