

Patient Requests for Restriction: Service Estimate Methodology

Under new healthcare federal regulations the patient can elect to restrict us from billing their insurance for a visit, pay for the service, and restrict our ability to release information to certain parties, like payers. In order to “flag” these accounts outside our normal billing process, to prevent insurance from being loaded, and enable the Medical Center to track these patients through automated processes, we have elected to set up a third party plan code.

Below is the recommended approach for handling these requests for restriction based upon the type of encounter.

Staff who enter insurance plan codes:

The business offices have set up a unique plan code for Patient Restriction (Medipac: TG6; EPIC payer/plan: 111/2072) to be used by the staff only for those patients invoking their right for patient restriction request.

The staff responsible for loading the insurance plan code would register the patient who has requested the patient restriction under the unique plan code. This would allow these accounts to be hand held through the accounting systems. This would provide the “flag” to prevent insurance being added to the account and billed without proper revocation of the agreement with the patient. The plan code would serve as a flag to the business offices to not release information regarding the services when receiving calls. Having a unique registration with a plan code allows for tracking and reporting on this patient population.

A Request for Restriction is not the same as Self Pay. Clinic staff, ED staff, and all points of patient contact need to listen for key words from the patient identifying a request to not disclose information to the patient’s insurance plan as this type of request must stop routine processing steps and the patient is referred to speak with a core group of staff trained to educate the patient about what their request really means. The patient will need to sign the “Restriction on Release of Information to Insurance Plan Agreement”. The patient will be provided a quote by the appropriate financial counselors (VMG Business office for clinics, ED Registration supervisors for Inpatient and ED). Senior leadership determined it was appropriate to treat these restricted patient accounts as cash paying patients, meaning the 50% uninsured discount mandated by Tennessee law will apply to these patients. The account will be discounted by the Business Office staff based on being registered with the Patient Restriction plan code. Retail Pharmacy prescription services will not be included in the patient restriction agreement between Vanderbilt University Medical Center and the patient. The patient is informed during the review of the Restriction Agreement that the patient is responsible for informing their physician not to send an electronic prescription to the pharmacy and informing any retail pharmacy of their patient restriction request. Prescriptions filled by a Vanderbilt Retail Pharmacy are expected to be paid at 100% of charge by the patient before being disbursed. The 50% uninsured discount is not applicable to the pharmacy process (see section VIII below).

Methodology for arriving at the deposit amount required from the patient requesting to not bill their insurance under the Patient Restriction mandate. In order to make the most accurate determination of patient cost:

- I. For scheduled inpatient medical admissions and scheduled outpatient medical procedures: The staff will utilize the Relay Health Estimator tool (CPT Code driven) currently used for Point of Service collections to provide the patient an estimate of their cost (at 50% of the estimated charges) and request the amount of the estimate as the deposit payment at time of or prior to service. If the arrangement agreed to prior to service is for the patient to pay at time of service, then enter notes in Medipac so that admitting knows to collect the deposit.

In the event the patient has not paid by the date of service and prior to delivery of services and the patient still wishes to pay and restrict release, the Request for Restriction is not valid and the visit will be rescheduled. The patient will be referred to the appropriate financial counselor (VMG Business office for clinics and the ED Registration supervisors for the ED and inpatient admissions) for revocation of the patient restriction agreement. The patient will be then rescheduled and insurance loaded for proper verification and authorization of services.

- II. For scheduled clinic visits: The deposit amount will be the current flat rate estimated amount collected in the Point of Service collections process in the clinics today. These estimates are not discounted at quote time. In the event the patient has not paid prior to service and the patient still wishes to pay and restrict release, the visit will be rescheduled. The patient will be referred to the appropriate financial counselor (VMG Business office for clinics and the ED Registration supervisors for the ED and inpatient admissions) for revocation of the patient restriction agreement. The patient will be then rescheduled and insurance loaded for proper verification and authorization of services.
- III. For after hours clinic visits (including Walk-In clinics): If the patient initiates the request for restriction at a clinic location after normal business hours or on the weekend, the patient is advised the visit will need to be postponed until normal business hours (Monday – Friday). If the patient needs urgent care that should not be postponed to normal business hours, the patient is referred to the Emergency Department where the request for restriction can be accommodated.
- IV. For ED Visits: a deposit amount is required of \$2,500.00, set jointly by the Patient Accounting and VMG Business Offices based on an average total charge (technical and professional). The average total charge will be reviewed for changes annually and/or at the time of any price updates.

- V. For Observation: a deposit amount is required of \$ 12,700.00 , set jointly by the Patient Accounting and VMG Business Offices based on an average total charge (technical and professional). The average total charge will be reviewed for changes annually and/or at the time of any price updates.
- VI. For urgent /emergent /unscheduled medical Inpatient admissions a deposit amount is required of \$37,000, set jointly by the Patient Accounting and VMG Business Offices based on an average total charge (technical and professional) of admissions in these areas. The average total charge will be reviewed for changes annually and/or at time of any price updates. The estimator tool (CPT drive) is not used in the cases of the unscheduled visits due to no availability of the CPT code for service being rendered.
- VII. For urgent /emergent /unscheduled psychiatric Inpatient admissions a deposit amount is required of \$4,000.00 based upon an average length of stay of 5 days and an average daily charge of \$800. The average total charge will be reviewed for changes annually and/or at time of any price updates. The estimator tool (CPT drive) is not used in the cases of the unscheduled visits due to no availability of the CPT code for service being rendered.
- VIII. For scheduled Psychiatric inpatient admissions a deposit amount is required of \$4,000.00 based upon an average length of stay of 5 days and an average daily charge of \$800. In the event the patient has not paid prior to service, the visit will be rescheduled. The patient will be referred to the appropriate financial counselor (Hospital Registration Specialist at VPH) for revocation of the patient restriction agreement. The patient will be then rescheduled and insurance loaded for proper verification and authorization of services.
- IX. For scheduled Psychiatric Partial Hospital visits a deposit amount is required of \$4,000.00 based upon an average length of stay of 5 days and an average daily charge of \$800. In the event the patient has not paid prior to service, the visit will be rescheduled. The patient will be referred to the appropriate financial counselor (Hospital Registration Specialist at VPH) for revocation of the patient restriction agreement. The patient will be then rescheduled and insurance loaded for proper verification and authorization of services.
- X. Retail Pharmacy prescription services will not be included in the patient restriction agreement between Vanderbilt University Medical Center and the patient. The patient is made aware by the financial counselors as part of their patient restriction request; it is the patient's responsibility to inform their physician not to send an electronic prescription to the pharmacy and also to inform the retail pharmacy of their patient restriction request. Prescriptions are expected to be paid at 100% of charge by the patient before being disbursed. The 50% uninsured discount is not applicable to the pharmacy.
- XI. Overpayments: If an overpayment results once the 50% discount is applied to the patient's account by the business office, Vanderbilt would review if patient has other outstanding patient

balances due to Vanderbilt Medical Group or to Vanderbilt Medical Center. If so, the patient overpayment would be applied to these visits. If there are no outstanding balances, the patient overpayment would be refunded.

This methodology and the associated fee schedules are maintained and up-dated as needed by the Department of Finance and made available for internal use on the Department of Finance SharePoint site. Updates are communicated by Finance to the Financial Counselors and the Manager, Registration Systems and Training.