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THE UNIVERSITY OF KANSAS HEALTH SYSTEM

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Area	Fiscal Management
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Financial Clearance

SCOPE:

The University of Kansas Health System is committed to providing medically urgent services to patients regardless of their ability to pay. This policy applies to all scheduled patients who receive services at the Health System, in accordance with all state and Federal guidelines, including the No Surprises Act ("NSA"). Delivery of charitable care and financial assistance does not obligate the Health System to provide continuous care, unless the services and support are unique to our organization. Exceptions to this policy include:

A. Urgent/emergent services including all services covered under the Emergency Medical Treatment and Labor Act (EMTALA);
B. Transplant patients within the scope of the Solid Organ Transplants Policy (see Addendum C);
C. Foreign citizens residing outside the United States within the scope of the International Patient Policy (see Addendum B);
D. Unless specifically covered by insurance or required for procedure:
    1. Genetic counseling
    2. Cosmetic or elective services
    3. Dental services
    4. Reproductive endocrinology
    5. Experimental and investigational procedures
    6. Generally non-covered services by industry standards
E. People identified as not being able to comply with processes due to mental and physical

disabilities

F. Legal exceptions as per guidance from The University of Kansas Health System's Legal/ Compliance Department.

G. Patients receiving care at a Federally Qualified Health Center (FQHC)

PURPOSE:

This policy provides guidelines to financially secure appropriate reimbursement for scheduled patient services and manage a patient's expectations for financial responsibility prior to the provision of care. This document outlines the criteria for determining financial risk, as well as the criteria for patient compliance in resolving financial risk, according to the NSA.

DEFINITIONS:

Financial Clearance – Process to ensure financial and administrative obligations are met prior to the scheduled service.

Medically Urgent – Services deemed by the patient's ordering physician to be needed by the initially scheduled service date.

Pre-certification – The process by which health system staff contact a patient's insurance company (or third-party intermediary) and the insurance company confirms eligibility and collects information prior to inpatient admission and selected ambulatory procedures and services. The insurance company provides a pre-certification number and the number of days the patient is covered for the admission.

Pre-authorization – Acknowledgement and approval by the patient's insurer that a patient will be receiving specific medical services within a specified timeframe. The insurance company provides an authorization number for the service(s).

Uninsured – Patient has no form of third-party coverage to assist with financial responsibility for medical services.

Health System – The University of Kansas Health System

Underinsured — Patient has third-party coverage but benefits are such that the patient will be responsible for a significant portion of the financial responsibility.

Managed Care – A system of providing health care that is designed to control costs through managed programs in which the physician accepts constraints on the amount charged for medical care and the patient is provided with a specific pool of contracted physicians.

Third Party Liability (TPL) – The TPL payer is the payer of last resort for accident and liability cases. This coverage is from the party found to be liable for the accident or injury. This payer may be, but is not limited to: auto, personal liability, or commercial carriers (This does not include Personal Injury Payment (PIP) coverage from auto insurers).

POLICY

A. **The Financial Clearance policy and procedure will apply to the following financial risk categories:**

1. Uninsured/Non-covered: Patients who do not have active health insurance coverage, or their insurance does not cover the services scheduled;
2. High Expected Liability/Underinsured: Patients who will owe $5,000 or more for upcoming services;
3. No Pre-Cert/Authorization: Patients without a pre-certification/pre-authorization from their managed care company if required for services; and
4. Missing Critical Data: Patients missing critical data elements needed to verify eligibility (i.e., proof of insurance, diagnosis).
5. Out of Network / Non-contracted: Patients who have insurance but are not contracted with the Health System.

B. **Procedures/Standards and Roles & Responsibilities**

During the scheduling and pre-registration process for non-urgent/non-emergent services, staff shall inquire as to the patient's insurance status, and the following steps will be taken to financially secure the account by risk category.

C. **Out of Network/Non-contracted**

1. Patients should be referred to an in-network or contracted provider or facility
2. Out of network/non-contracted patients electing to have claims submitted to insurance are ineligible for self-pay discounts or financial assistance

D. **Uninsured / Non-covered**

1. Patient services may be rescheduled or deferred if the patient refuses to assist staff by providing financial and/or demographic information necessary to establish:
    a. Current insurance eligibility;
    b. Potential for insurance eligibility through Medicaid or the Health Insurance Exchange during open enrollment periods;
    c. Ability to pay for services as a self-pay; and
    d. Need for financial assistance.
2. Uninsured / non-covered patients scheduling services at least three(3) business days in advance shall receive a good faith estimate as required by the NSA. Uninsured / non-covered patients may also receive a good faith estimate upon request.
3. Patients seeking care for services not covered by their insurer (i.e., non-covered service) or who opt not to submit claims to their insurer will be registered as Self-Pay according to department procedures.

E. **High Expected Liability/Uninsured**: See All Patients

F. **No Pre-Cert/Authorization**:

1. If services require prior authorization by the patient's insurance company, a valid

authorization number is required no later than two (2) business days in advance of the procedure date in order to financially secure the account and to prevent the service from being rescheduled or deferred.

2. If an authorization is not obtained, the patient may choose to proceed with the service after paying their estimated patient liability, and they will be informed of their responsibility to pay remaining charges and required to sign an ABN or waiver if the insurer does not authorize their service.

G. **Missing Critical Data**:

1. All missing critical data elements are required at the time of scheduling in advance of the procedure date in order to financially secure the account and to prevent the service from being delayed or deferred.
2. Either the patient or the patient's ordering physician is required to provide third-party insurance coverage information or identify as self-pay. This information is used to determine the patient's potential liability and ability to pay patient balances incurred as a result of medical center services provided.

H. **All Patients**

1. All estimated patient liabilities for non-urgent/non-emergent services are collected prior to or at time of service to include co-pays, deductibles, co-insurance and outstanding balances in accordance with the Payment Arrangement Guidelines.
    a. Upcoming Service Liability: If the patient has an upcoming liability of $5,000 or more, the patient is required to pay a deposit in accordance with Payment Arrangement Guidelines in order to avoid service deferral. A payment arrangement will be requested for all liabilities not paid in full.
    b. Existing Payment Plan: If a patient has an existing payment plan and is current on payments, then only the new estimated liability will be due in accordance with Payment Arrangement Guidelines. Any remaining liability due after the minimum payment is paid will be applied to a revised payment plan.
2. If rescheduling is required due to lack of financial clearance requirements described above, Health System staff will work with the ordering physician's office to defer non-urgent scheduled procedures and allow sufficient timing to obtain required financial information and/or payment to consider the account financially secure prior to service date. See Service Deferral Determination under section 10 of the procedure.
3. Deferred services will be tracked and reported to Revenue Cycle management on a regular basis for policy effectiveness reviews.
4. Medical Clearance: All patients, including United States Citizens, are required to submit medical records (in English), at their own expense, for review by the Patient Coordinator, applicable patient navigator, or other designated staff, depending on the line of business.
5. Commercially Insured patients have the right to choose to not have their medical insurance billed. Patients electing this option will be billed as Self-Pay and will be required to follow the Self-Pay Collections Policy #6468422. If the patient chooses

to file insurance at a later date, UKHS will provide the claim form to the patient to file themselves.

I. **Procedures**

1. When pre-registering a patient for scheduled, non-urgent/non-emergent services, each patient must be financially cleared by a Pre-Service representative or Financial Advising (FA) representative during the pre-service process. The process is conducted as far in advance as possible but no less than two (2) days prior to service.
2. Insured patients are expected to pay all co-pays, co-insurance and deductibles at the time of service.
3. Self-pay patients are expected to pay in accordance with these guidelines:
    a. For medically necessary services: The patient estimate amount is due at the time of service. For planned treatment and surgical procedures, self-pay patients are expected to pay 50% of the estimated amount due at the time of service, and secure the remaining balance in accordance with the health system's payment arrangement guidelines, as outlined in Addendum A.
    b. For services generally not covered by industry standards and/or which represent pre-packaged pricing: The full estimated amount is due at the time of scheduling, or 15 days prior to the procedure, whichever comes first.
4. All authorizations and/or referrals are due at the time of service. It is the responsibility of the patients to obtain insurance referral authorizations from their primary care physicians. The referral should specify the name of the provider the patient will see and the time range the referral will cover.
5. Financial clearance takes into consideration the Health System's financial risk for a scheduled service to proceed. There are four (4) key financial risk categories to satisfy for financial clearance:
    a. Uninsured/Non-covered
    b. High Expected Liability/Underinsured
    c. No Pre-Cert/Authorization
    d. Missing Critical Data
6. If one or more financial risks are uncovered during the financial clearance process, the patient's service may be deferred until financial clearance can be achieved.
7. Uninsured/Non-covered
    a. Definition: Patients without active health insurance coverage, or patients with insurance and the insurer does not cover the patient's scheduled services. This population should be reviewed by Financial Advising staff for payment review and collection of liabilities to include upcoming liabilities and/or outstanding liabilities.
    b. If patient is uninsured with no active health insurance coverage or is

'pending' coverage, Financial Advising staff will request the patient to pay estimated patient liabilities after the self-pay discount has been applied, outstanding balances, and/or bad debt. If the patient expresses an inability to pay, then:

i. Financial Advising Representatives will work with the patient prior to service to determine eligibility for enrollment in Medicaid or commercial insurance through the Health Insurance Exchange (HIX). HIX enrollment is limited to the open enrollment period as determined by the Federal Department of Health and Human Services.

ii. Once the patient has applied for an insurance plan or government assistance, the patient will be requested to defer their service until the coverage effective date plus additional days to allow for financial clearance per Payer Guidelines. Medical urgency will first be reviewed before the service is deferred. See Service Deferral Determination.

c. If scheduled services are non-covered per the patient's insurer, the patient will be provided with the following options:

i. Postpone services and reschedule with a contracted provider. If the patient chooses this option, Pre-Service Representatives will contact the patient's ordering physician's office to let them know of the patient's decisions to postpone services. The physician's office is responsible for removing the patient from the schedule.

ii. Continue services as planned. The patient will be informed that services will not be covered by their insurer, and the patient will be required to sign an ABN or waiver and payment will be expected in accordance with this policy and the Financial Assistance Policy. The patients' insurance will still be added in the HIS and billed as it would have been otherwise.

d. If a patient has a liability due, the patient will be requested to pay the liabilities in accordance with Payment Arrangement Guidelines and establish a payment arrangement for the remainder of the liability.

e. If the patient refuses to pay in accordance with Payment Arrangement Guidelines, the service will be reviewed for deferral. See Service Deferral Determination.

8. High Expected Liability/Uninsured

a. Definition: Patients who will owe $5,000 or more for upcoming services. This population should be reviewed by Pre-Service/Financial Advising staff for payment review and collection of liabilities to include upcoming liabilities and/or outstanding liabilities.

b. If the patient has a high expected liability due for an upcoming service, the patient is required to pay a deposit in accordance with Payment Arrangement Guidelines in order to avoid service deferral. A payment

arrangement will be requested for all liabilities not paid in full.

c. If the patient expresses financial hardship for their high expected liability prior to service, a Financial Advising representative may screen the patient for applicable programs to include Financial Assistance in accordance with the Health System's Financial Assistance Policy.

d. If the patient refuses to pay in accordance with Payment Arrangement Guidelines and does not qualify for Financial Assistance, the service will be reviewed for deferral. See Service Deferral Determination.

9. No Pre-Cert/Authorization

    a. Definition: When the patient's insurer requires authorizations for services, the authorization must be obtained at least two (2) business days in advance of service date (e.g., by end of day Monday for a Wednesday procedure) in order to avoid service deferral.

    b. When insurance authorization is required but not obtained at least two (2) business days in advance of service date, a Pre-Service Representative will contact the patient's ordering physician's office to determine if an authorization number is on file. If the Pre-Service Representative is unable to obtain the authorization, see Service Deferral Determination.

    c. If an insured patient presents day of service without an authorization on file, the Registrar will inform the patient that authorization is required but an authorization is not on file. The Registrar will contact Financial Advising, who will counsel the patient and perform the following:

        i. Communicates all previous attempts to secure the authorization from the patient's ordering physician's office and patient's insurance company.

        ii. Communicates whether attempts were made to contact the patient prior to arrival.

        iii. Financial Advising makes an urgent final attempt to secure authorization through the physician's office and/or payer.

        iv. If authorization is secured, procedure occurs as planned.

        v. If the authorization cannot be obtained, the patient may choose to proceed with the service after paying their estimated patient liability, and they will be informed of their responsibility to pay remaining charges and required to sign an ABN or waiver if the insurer does not authorize their service. If the patient chooses not to proceed, see Service Deferral Determination.

10. Missing Critical Data

    a. Definition: Patient is missing critical data elements needed to verify eligibility and financially secure the account.

    b. Attempt to collect any missing demographic or insurance information. The Health System will postpone any non-urgent/non-emergent service if critical data elements cannot be collected by the payer, patient, or

physician. Critical data elements include:

i. Patient Name
ii. Patient Date of Birth (DOB)
iii. Patient Address
iv. Patient Phone Number
v. Patient Social Security Number
vi. Patient Sex
vii. Patient Primary Care Physician (PCP)
viii. Accident Information
ix. Guarantor Information (if dependent)
x. Procedure Narrative/CPT Code
xi. Diagnosis Code
xii. Proof of Insurance
xiii. Insurance Carrier/Group Policy Information
xiv. Authorization Number (if required)

c. If any of the critical data elements required to financially clear the patient remain missing two (2) days prior to service, we may defer service (see Service Deferral Determination).

11. Pending Coverage Considerations
    a. Scheduled patients pending Third Party Liability (TPL) coverage verification and seeking services will be registered as Self-Pay unless the patient has active commercial coverage. If TPL coverage is denied, the patient's insurance will be billed in accordance with their existing coverage. Should TPL be verified, the billing order should be:
        1. Patient's auto insurance for PIP coverage (if auto related and there is coverage);
        2. Patient's health insurance (if there is coverage); and
        3. TPL coverage
    b. Scheduled patients pending Worker's Compensation claim verification will be registered as Self-Pay. If a Worker's Compensation claim is denied and is not part of an existing or new claim, the patient is able to use their commercial insurance if available.
12. Special Considerations – Emergency Department
    a. Patients undergoing treatment in the Emergency Department will be stabilized in accordance with EMTALA guidelines.
    b. Prior to the scheduling of non-urgent/non-emergent follow-up care within the Health System continuum of care, patients will be referred to a

Financial Advisor to complete the policy steps outlined in sections 1-9 above and will be evaluated for Service Deferral Determination as defined in section 11 below, if necessary.

13. Service Deferral Determination
    a. Definition: The process used by Financial Advising Representatives to contact the patient's ordering physician for the physician to determine if a patient's service can be deferred.
    b. Pre-Service staff or Financial Advising will contact the physician's office to determine if the procedure can be deferred due to lack of financial clearance, or if the physician deems the procedure medically urgent and the patient must proceed with services as planned.
        i. If the patient's procedure is deemed medically urgent by the ordering physician, ***the procedure will proceed as planned regardless of ability to pay***.
        ii. If the physician is unavailable to provide a medical urgency determination, ***the procedure will proceed as planned regardless of ability to pay***.
        iii. Financial Advisors must enter thorough account notes regarding the outcome of Service Deferral Determination and apply the corresponding FPL status in Epic.
    c. If the service is not medically urgent and can be deferred, Pre-Service staff or Financial Advising will notify the patient's ordering physician to reschedule the patient's service utilizing the Financial Clearance Rescheduling Process.
    d. Department leadership will be notified of deferrals as needed. See Reporting.
14. Reporting
    a. Efforts will be made to track 1) cases deferred due to financial clearance requirements and 2) cases for which financial requirements were not met, but services were provided due to medical urgency. The Health System's Vice President of Revenue Cycle will determine ownership and distribution for reporting.

J. Enforcement and Exceptions
    1. Failure to comply with this policy may result in disciplinary action up to and including termination of employment for employees or termination of contract or service for third-party personnel, students or volunteers.

REFERENCES:

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SUPPORTING DOCUMENTS:

This section intentionally left blank.

REVIEWED/APPROVED BY:

Vice President - Revenue Cycle, Financial Clearance Workgroup

Director - Patient Admitting, Financial Clearance Workgroup

Financial Advising Manager, Financial Clearance Workgroup

Director - Patient Financial Services, Financial Clearance Workgroup

Assistant Director - Patient Financial Services, Financial Clearance Workgroup

Director – Physician Revenue Cycle, Financial Clearance Workgroup

Health System Controller, Financial Clearance Workgroup

Director – Shared Revenue Cycle Services, Financial Clearance Workgroup

ADDENDUM A – PAYMENT ARRANGEMENT GUIDELINES

A. Definition: Criteria used to determine the patient's payment plan terms for upcoming liabilities or outstanding balances.

B. The following Payment Arrangement Guidelines will be used to determine a patient's payment plan terms for any remaining or outstanding balance. That balance does not include co-pays, which are due at the time of service, as explained above under 'Procedures'. The external terms are consistent with those that will be available to patients through the health system's designated patient loan vendor:

	Payment Arrangement Guidelines	
	Current + Outstanding Patient Balance	**Payment Plan Terms (minimum $25/month)**
Internal	$0+ (Default Internal Payment Arrangement for All Patient Balances)	10%, Up to 10 Month Term
External	$0 - $1,000	Up to 12 Month Term
	$1,001 - $3,000	Up to 24 Month Term
	$3,001 - $5,000	Up to 36 Month Term
	$5,001 - $7,500	Up to 48 Month Term
	$7,501+	Up to 60 Month Term

ADDENDUM B – INTERNATIONAL PATIENT

SCOPE:

The Health System is committed to delivering world-class patient care to the people of Kansas and

surrounding areas. This policy applies to all non-US citizens (international patients) who are seeking services at The Health System. Exceptions to this policy include:

A. Urgent/emergent services including all services covered under the Emergency Medical Treatment and Labor Act (EMTALA);
B. US citizens and patient populations within the scope of the Financial Clearance Policy;
C. Transplant patients within the scope of the Solid Organ Transplants Policy (see Addendum C);
D. Patients within the Health System continuum of care (approved by both clinical and financial leadership), unless a physician medical review has determined discontinuation or deferral of care is appropriate;
E. Exceptions as per guidance from the Health System's Legal/Compliance Department.

PURPOSE:

This policy provides guidelines to complete medical and financial clearance requirements for international patient services prior to the provision of care.

DEFINITIONS:

International Patient – Any patient who is not a citizen of the United States (US) residing outside the US seeking medical services from the Health System.

Medical Clearance – Process to ensure international patient medical records are reviewed by a physician to warrant services by the Health System are necessary prior to scheduled services.

Financial Clearance – Process to ensure financial and administrative obligations are met prior to scheduled services.

POLICY:

A. The International Patient policy and procedure will require completion of the following steps prior to the scheduling of patient services:
    1. Medical Clearance:
        a. Patients are required to submit medical records (in English) for review by the International Patient Coordinator, applicable patient navigator, or other designated staff, depending on the line of business
        b. Based on diagnosis, the designated staff will coordinate with the appropriate department to conduct a physician review of the patient's medical history to determine specific treatment(s);
        c. The reviewing physician will provide a detailed plan of care to enable the designated staff to prepare an estimate of charges prior to scheduling services
    2. Financial Clearance:
        a. Self Pay Patients – Patients will be provided an estimate for services that

must be paid in full prior to scheduling any services.

b. Insured Patients – Patients will provide documentation to verify international insurance coverage and benefits for select plans accepted by The Health System. The designated staff will coordinate with the insurance plan to ensure the patients' coverage is active, benefits will cover their care, and necessary authorizations are secured prior to scheduling services. In the event that benefits do not cover planned services, patients will be registered as self pay and required to follow self pay steps.

c. Embassy/Corporate-sponsored Patients – Patients sponsored by embassies or corporations must have a valid letter of guarantee prior to scheduling services.

B. Enforcement and Exceptions

1. Failure to comply with this policy may result in disciplinary action up to and including termination of employment for employees or termination of contract or service for third-party personnel, students or volunteers.

REFERENCES:

This section intentionally left blank.

SUPPORTING DOCUMENTS:

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REVIEWED/APPROVED BY:

Vice President - Revenue Cycle, Financial Clearance Workgroup

Director - Patient Admitting, Financial Clearance Workgroup

Financial Advising Manager, Financial Clearance Workgroup

Director - Patient Financial Services, Financial Clearance Workgroup

Assistant Director - Patient Financial Services, Financial Clearance Workgroup

Director – Physician Revenue Cycle, Financial Clearance Workgroup

Health System Controller, Financial Clearance Workgroup

Director – Shared Revenue Cycle Services, Financial Clearance Workgroup

ADDENDUM C – SOLID ORGAN TRANSPLANTS

SCOPE:

The Health System is committed to providing solid organ transplant services to patients. This policy

applies to all patients who are seeking non-emergent solid organ transplant services at the Health System. Additionally, the policy applies to both transplant recipients and living donors, as applicable. Exceptions to this policy include:

A. Trauma or emergent services;
B. Services that are unrelated to the direct transplantation;
C. Outpatient pharmacy services;
D. Services provided more than a designated number of days (i.e., varies by transplant) after discharge from the transplant admission;
E. Exceptions, as per guidance from the Health System's Legal/Compliance Department.

PURPOSE:

This policy provides guidelines to complete financial clearance requirements for non-emergent solid organ transplant services and manage a patient's expectations for financial responsibility prior to the provision of care.

DEFINITIONS:

Financial Clearance – Process to ensure financial and administrative obligations are met prior to scheduled solid organ transplant services.

Pre-authorization – Acknowledgement and approval by the patient's insurer that a patient will be receiving specific medical services within a specified timeframe. The insurance company provides an authorization number for the service(s).

Uninsured – Patient has no form of third-party coverage to assist with financial responsibility for medical services.

POLICY:

A. The Solid Organ Transplants policy and procedure will require completion of the following financial clearance steps prior to the scheduling of patient services:
    1. Self Pay Patients:
        a. Uninsured patients will meet with a Financial Advisor prior to scheduling a medical appointment.
        b. The Financial Advisor will present the patient and/or guarantor with a required deposit amount, which the patient and/or guarantor must pay prior to beginning evaluation for transplant services.
    2. Insured Patients
        a. Patients will provide documentation to verify insurance coverage and benefits for plans accepted by the Health System
        b. The Pre-Service staff will coordinate with the insurance provider to ensure the patient's coverage is active and the benefits will cover their care

c. Any corresponding pre-authorizations must be obtained in conjunction with evaluation for solid organ transplant services

d. In the event that benefits do not cover transplant services or pre-authorization is not obtained, a Financial Advisor will work with the patient as self pay, following the self pay steps.

B. Enforcement and Exceptions

1. Failure to comply with this policy may result in disciplinary action up to and including termination of employment for employees or termination of contract or service for third-party personnel, students or volunteers.

REFERENCES:

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SUPPORTING DOCUMENTS:

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REVIEWED/APPROVED BY:

Vice President - Revenue Cycle, Financial Clearance Workgroup

Director - Patient Admitting, Financial Clearance Workgroup

Financial Advising Manager, Financial Clearance Workgroup

Director - Patient Financial Services, Financial Clearance Workgroup

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Approval Signatures

Step Description	Approver	Date

Jennifer Palmer: Health System Policy Administrator	07/2025
Douglas Gaston: SVP & Chief Financial Officer	07/2025
Colette Lasack: VP, Revenue Cycle Operations	07/2025