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| **Name of Policy**: Financial Clearance: Elective Services<br><br>**Policy Number**: 3364-146-03<br><br>**Approving Officer**: Chief Financial Officer, Chief Executive Officer<br><br>**Responsible Agent**: Director, Patient Access<br><br>**Scope**: University of Toledo Medical Center |  <br><br>**Effective date:** 4/2025<br><br>**Original effective date**: 1/1/2021 |
| Key words: Financial Clearance, Elective Services, Assistance, Revenue Cycle, Eligibility | |

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| ☐ | New policy proposal | ☒ | Minor/technical revision of existing policy |
| ☐ | Major revision of existing policy | ☐ | Reaffirmation of existing policy |

**(A) Policy Statement**

As a non-profit organization, University of Toledo Medical Center ("UTMC") offers financial assistance on a case-by-case basis to all patients receiving medical treatment in accordance with its financial assistance policies. Before a patient is eligible for financial assistance from UTMC under its charitable care policy, UTMC requires that (1) a patient be approved for financial assistance by the Revenue Cycle Department and (2) the medical treatment at issue is deemed medically necessary by the patient's treating physician. This policy addresses financial clearance policy and circumstances under which UTMC may delay or deny provision of elective services to patients.

**(B) Purpose of Policy**

Provide a standard procedure for financial clearance and determining whether a delay or denial of elective medical services is appropriate for patients not approved for financial assistance by the Revenue Cycle Department or whose desired medical treatment is not medically necessary.

**(C) Definitions**

1. **Out of Network (OON)**: provider that is not contracted with an insurance company for reimbursement at a negotiated rate
2. **Ambulatory Clinical Services**: medical care provided on an outpatient basis within a physician clinic
3. **Elective Services**: non-medically necessary services scheduled in advance because no medical emergency is involved
4. **Emergency Medical & Labor Act (EMTALA)**: 42 U.S.C. § 1395dd, ensuring public access to emergency services regardless of ability to pay
5. **Emergent Services**: medically necessary services for individuals experiencing an "emergency medical condition" as such term is defined by EMTALA at 42 U.S.C. § 1395dd(e)
6. **Good Faith Estimate (GFE)**: a document that lists the expected costs for a service or item. It is based on information known at the time the estimate is created. UTMC follows the No Surprises Act on GFE guidelines.

**(D) Policy**

1. Generally:
   a. Emergent services will never be denied or deferred to any patient.
   b. Elective Services may be delayed or denied only with the written approval of the UTMC Chief Medical Officer (or their designee), where medical necessity is considered.
   c. Patient Access staff will follow standard operating procedures to financially clear all patients and services.

2. Hospital Inpatient, Hospital Outpatient and Ambulatory Clinic Services:
   a. Scheduled hospital and clinic services require Good Faith Estimate for self-pay patients that must be paid in full prior to service.
   b. Scheduled insured patients are required to pay their copayment prior to service.
   c. Financial assistance
      i. Staff will refer uninsured and underinsured patients to the Patient Access Department for determination of financial assistance approval under UTMC's patient financial assistance policies.
      ii. If the self-pay patient is not approved for financial assistance or has not paid the GFE in full, the patient's account will be reported to ordering physician and Patient Access manager.

3. Delay of Elective Services - Services may be delayed:
   a. While pending a financial assistance determination as described in Sections D(2)above; and/or
   b. When the Patient Access Department has not received formal insurance prior authorization or appropriate financial clearance as outlined in departmental standard operating procedures

4. Denial of Elective Services. The following criteria will be used to determine when Elective Services may be denied if not medically necessary:
   a. During the financial clearance process, UTMC establishes that the patient has:
      i. No OON benefits or non-covered service:
         1. Staff shall supply patient with a quote for OON benefits when applicable and available.
            a. If the patient decides to have services, they must complete an Advance Patient Notice of Noncoverage form and pay the GFE in full prior to service
         2. Staff will refer patients with no OON benefits to in-network facility/providers for services.
      ii. No insurance coverage.
      iii. Patient does not qualify for financial assistance.

5. Reporting Denials. All services delayed or denied in accordance with this policy shall be reported to the Patient Access Director, Revenue Cycle Director, Ordering Physician, Chief Medical Officer, and Chief Financial Officer within the same business day via email.
   a. Patient Access will communicate the delay/deny to the service department and patient.

6. Record Maintenance. Patient Access will maintain record of all delayed or denied services. Record to include:
   a. MRN
   b. Ordering Physician
   c. Date of service
   d. Service
   e. Reason for denial or delay
   f. Communication of denial or delay as defined in Section D(7)
   g. CMO approval of denial or delay and consideration of medical necessity as described in Section D(1)(b).

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| Approved by:<br><br>/s/<br>_____<br>Troy Holmes<br>Chief Financial Officer<br><br>4/28/2025<br>_____<br>Date<br><br>/s/<br>_____<br>Daniel Barbee<br>Chief Executive Officer<br><br>4/28/2025<br>_____<br>Date<br><br>*Review/Revision Completed by:*<br>*Director, Patient Access, Chief Financial Officer* | **Policies Superseded by This Policy:**<br>• *None*<br><br>Initial effective date: 1/1/2021<br><br>Review/Revision Date:<br>1/1/2021<br>4/2025<br><br>Next review date: 4/2028 |