PPO Policy and Patient CAP Procedure

(SFHN – ZSFG and COPC)

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Reviewer	Timothy Arnold	**Effective:**	**02/01/2019**	**Page**	**1**	**of**	**2**

Policy Statement:	To ensure appropriate actions are taken once a PPO Payer applies payment reductions
Procedure:	• If a PPO Health Plan applies UCR reductions / reason code 45 1) Document EPIC and send appeal 2) Submit adjustment under AR Code: 2436 • If a PPO Health Plan applies Out-Of-Network reductions / reason code 242: 1) Document EPIC and send appeal 2) Submit adjustment under AR Code: 2451 • If a patient is seen within SFHN, and their insurance has adjudicated the services as Out-Of-Network, they will only be held liable for their in-network co-insurance based on the in-network policy benefits. • If the Account balance is true Patient Liability, the following Patient CAP adjustments should be applied: **INPATIENT CAP of $4,800.00:** • If the guarantor has a true patient liability (co-insurance, copay and deductible) that is over the Patient Cap amount, apply adjustment code: 2469, document EPIC, and NRP balance of $4,800.00 to the Patient Bucket. • If the patient has secondary insurance, we will not reduce the patient liability. We will continue to bill the patient liability shown on the EOB to the secondary payer. **OUTPATIENT CAP of $1,000.00:** • If the guarantor has a true patient liability (co-insurance, copay and deductible) that is over the Patient Cap amount, apply adjustment code: 2469, document EPIC, and NRP balance of $1,000.00 to the Patient Bucket. • If the patient has secondary insurance, patient liability will not be reduced and the patient liability shown on the EOB will be billed to the secondary payer.
Auditing:	• Standard Finance/Controller Auditing
Automation:	1. For Inpatient and All Commercial "Contracted" Payers, RMC logic will post adjustment(s) when RMC 45 is present to ensure the patient is not balance billed outside of true Patient Liabilities (e.g. Deductible; Co-Insurance etc). • Follow-up Staff are required to review all accounts prior to closing to ensure maximum reimbursement is received.

2. For Inpatient and All Commercial "Non-Contracted" Payers, RMC logic will not auto-post any adjustments.
    - Follow-up Staff are required to review all accounts prior to closing to ensure maximum reimbursement is received, and apply the necessary adjustment(s) not applied by the system for "Non-Contracted" payors, as needed.

3. For Patient Cap, if the insurance ANSI reason code includes PR100 (insurance paid patient directly), no Patient Cap will be applied.
    - Staff will document EPIC and add Billing Indicator 251 (Excluded from Patient Cap).
    - System will automatically NRP the balance to the Patient Bucket.
    - Follow-Up staff then send a letter requesting the guarantor to forward the insurance payment to the hospital.
    - Once the insurance payment is received and posted, Patient Cap is applied if needed.

References:

- 04/16/2019 (Retroactive to 02/01/2019) HC Approved Balance Billing Policy Change (Attachment #1 - ZSFG Balance Billing HC 4.16.19 Finala.pdf)