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<b>Policy Name:</b> Discount Policy			

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**Purpose**

This Discount Policy (“Policy) provides the operational guidelines for additional discounts for patients not eligible under the Financial Assistance Policy.

**Scope**

This Policy is not for:

- Patients who are eligible pursuant to ECRMC’s Financial Assistance Policy.
- Patients with government benefits (including Medicare and Medicaid) to the extent that such non-covered benefits have a direct or indirect relationship to services reimbursable by any government program.

Discounts pursuant to this Policy are only available for medically necessary services provided under ECRMC’s general acute care hospital license.

The following services are excluded as ineligible for discounts under this Policy, except as required by law:

- Purchases from ECRMC’s retail operations, such as gift shops and cafeteria;
- Physician professional services that are not billed by ECRMC;

Services that are not licensed hospital services are not covered by this Policy

**Responsibilities**

Person/Title	Responsibilities

26 **Procedure/Plan**

27 **I. Self-Pay Patient Discounts**

28 **A. Deposit Requirements of Certain Self-Pay Patients**

29

30 All Self-Pay Patients not eligible for the ECRMC Financial Assistance Program must remit prior to  
31 the provision of scheduled, non-emergent services a deposit of thirty percent (30%) of the total  
32 amount of the estimated charges to be incurred during the encounter.

33

34 **B. Prompt Pay Discount for Certain Self-Pay Patients**

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36 A Self-Pay Patient who is not eligible for Financial Assistance shall be provided a prompt pay  
37 discount. The prompt payment discount is equivalent to a thirty percent (30%) discount off of  
38 charges.

39

40 A patient who directs ECRMC to not share health information to available commercial/private  
41 third-party insurance, e.g., who directs ECRMC to not submit a claim to such available third-party  
42 insurance, may receive a prompt pay discount after executing an Acknowledgment of Self-Pay  
43 Status form or another form of similar effect.

44

45 The amount written off of the patient account because of the prompt pay discount may not be  
46 classified as bad debt.

47

48 **C. Eligibility for Prompt Pay Discount**

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50 To qualify for a prompt pay discount, Self-Pay Patients must submit payment in full within thirty  
51 (30) days of the date the bill is submitted to the patient.

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53 **D. Changes in Insurance Status**

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55 The eligibility for the prompt payment discount shall be based on the patient's insured status at  
56 the time services are rendered and shall give consideration to any retroactive denial or granting  
57 of insurance. That is, if the patient is believed to be insured at the time services are rendered but  
58 is subsequently found to have been uninsured at that time, then the patient may be eligible for  
59 a prompt pay discount. Similarly, if the patient is believed to be uninsured at the time services  
60 are rendered but is subsequently found to have been insured at that time, then the patient is not  
61 eligible for a prompt pay discount. A discount will be reversed in these situations.

62

63 Patients who decline to disclose his/her/their insurance status will be provided a discount until  
64 the hospital can establish whether the patient does have coverage.

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66 **II. Obstetric Patients Cash Price for Eligible Patients**

67 For all self-pay obstetric patients at the time of pre-admission or admission for walk-in patients,  
68 ECRMC may choose to cap a patient's liability to the average Medi-Cal reimbursement for two-  
69 day vaginal deliveries and three-day Cesarean Section deliveries, provided there are no  
70 complications with the delivery or the baby. Additional fees apply to patients that involve an  
71 extended stay, NICU babies, twins, tubal ligations, and any other services outside the delivery of  
72 the baby.

73  
74 To be eligible for this cap, a \$500 deposit must be provided at the time of registration and full  
75 payment must be made within 30 days of the date the bill is submitted to the patient. A deposit  
76 will not be required if the patient is in active labor.

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78 All walk-in patients will be first referred to the Financial Counselor unless the patient has either  
79 pre-registered or has a pregnancy that is over twenty weeks.

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81 This cap cannot be applied in conjunction with Financial Assistance, or any discounts described  
82 in this Policy.

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84 The eligibility for the cap shall be based on the patient's insured status at the time services are  
85 rendered and shall give consideration to any retroactive denial or granting of insurance. That is,  
86 if the patient is believed to be insured at the time services are rendered but is subsequently found  
87 to have been uninsured at that time, then the patient may be eligible for the cap. Similarly, if the  
88 patient is believed to be uninsured at the time services are rendered but is subsequently found  
89 to have been insured at that time, then the patient is not eligible for the cap. The cap will be  
90 reversed in these situations.

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92 Patients who decline to disclose his/her/their insurance status will be provided the cap until the  
93 hospital can establish whether the patient does have coverage.

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95 **Definitions**

Term	Definition
Self-Pay Patient	Is a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.