SLRC
St. Lawrence Rehabilitation Center

Policy/Procedure Manual: Finance

Subject: Financial Assistance Program & Billing Process Policy: #14.32
Date: 7/10/01, 5/10, 11/17

Approved: _____ Date: 11/2017
Chief Financial Officer

_____ Date: 11/2017
Director of Finance

Policy: The Center shall provide free care to patients who qualify based on financial criteria.

Purpose: To provide services to persons who are eligible for free care.

Scope: Center-wide

Accountability: Administrator
Chief Financial Officer
Director of Finance

Review: Triennial

Purpose:

St. Lawrence Rehabilitation Center (SLRC) is a not-for-profit healthcare institution that provides inpatient and outpatient physical rehabilitative therapy, whose mission includes improvement of the overall health status of the community it serves. SLRC is committed to providing high quality healthcare for patients who seek services, including those individuals in the SLRC community who lack the means to pay for such services. This policy sets forth the policy, process, and guidelines by which such patients can access charity care.

Policy and Scope:

To fulfill its mission of providing compassionate, high quality healthcare to the patients it serves, SLRC must provide such services in a financially responsible manner. Therefore, it is the policy of SLRC to maintain a system for proper identification of patients eligible for charity care.

This policy covers medically necessary healthcare services provided by SLRC and does not include any services provided by outside vendors, including, but not limited to, non-employed physicians.

It is the policy of SLRC to differentiate between uninsured patients who are unable to pay from those who are unwilling to pay for all or part of their care. SLRC will provide charity care to those uninsured patients who are unable to pay based upon the eligibility criteria set forth herein. In order to conserve scarce healthcare resources, SLRC will seek payment from uninsured patients who do not qualify for charity care. While qualification for charity care is ideally determined at the time of service, SLRC will continue to review such determinations as potential insurers or other financial resources are discovered during the billing and collection process.

Definitions:

1. Patient Billing Representative
   An individual trained to assist patients in identifying sources of healthcare coverage, determining eligibility for such coverage and assisting in completing necessary applications. Patient Billing Representatives may either be employees of SLRC or a third party engaged by SLRC to assist in its billing and collections processes.

2. Charity Care
   Charity care is free care provided to patients who are uninsured for the relevant, medically necessary service and who are ineligible for governmental or other insurance coverage. A patient will be eligible for charity care if the patient's family income does not exceed 200% of the Federal Poverty Level. All expenses incurred as a result of providing healthcare services to those who qualify for charity care are absorbed by SLRC.

3. Self-Pay Patient
   Those patients who are uninsured patients (as defined below) and who are not eligible for charity care. Self-pay patients are eligible for financial assistance at a discounted rate.

4. Uninsured Patient
   A patient who does not have any third party healthcare coverage by either (a) a third party insurer, (b) an ERISA plan, (c) a federal healthcare program (including without limitation Medicare, Medicaid, SCHIP and TRICARE), (d) Workers' Compensation, Medical Savings Account, or other coverage for all or any part of the bill.

5. Governmental Healthcare Coverage
   Any healthcare program operated or financed at least in part by the federal, state or local government.

Billing Process:

Inpatient bills are dropped every day approximately eighteen (18) days after discharge.

Outpatient bills are dropped on the 11th day of every month or the business day that follows, whichever comes first.

Secondary bills are dropped every day; some auto drop and others are done manually. Rebills are done manually.

All UB04's are downloaded into the E-Premis System. Inpatient - daily, Outpatient - monthly.

Inpatient claims are edited and submitted the same day. All other claims are edited and submitted within three (3) days. Problem and claims missing diagnosis are updated daily until all claims are submitted.

Claims are transmitted daily. Outpatient may take a few days, since done monthly.

Payments are manually posted through electronic remittances. All other payments are manually posted. The daily payments are separated by insurance company and reported to each representative according to their assigned Financial Class and Patient Type.

The representative will check for any denials and update the notes by indicating what procedure is taken.

Notes are used to explain the status of the account and document any work performed during this review.

Outpatient accounts are manually discharged after thirty (30) days of no charge/therapy activity. There are certain circumstances that warrant an outpatient account not to be discharged. These accounts are coded as permanent repeating outpatient. Circumstances that warrant an outpatient account not being discharged would be Psychology and Driving.

Write-Off Procedure:

Follow-up staff will review assigned accounts in conjunction with their job responsibilities and identify account transactions potentially eligible for write-off. Other Business Office staff may identify account transactions potentially eligible for write-off as part of their job responsibilities. Account transactions that meet write-off criteria may include accounts with billing errors that result in non-payment from a third party that cannot be billed to the patient, existing conditions, or an invalid service.

Staff will collect all data and supporting documentation relative to the write-off request.

Staff will prepare the Uncollected Accounts Write-Off Request with a detailed explanation regarding circumstances surrounding the write-off and forward it to the CFO.

The CFO will review the write-off request and sign approval or denial based on the following guidelines:

Employee	Approval Limits
Business Office Manager	Maximum of $5,000
Chief Financial Officer	$5,000 - $25,000
Administrator/CEO	$25,000 +

Compliance with Internal Revenue Code §501(r)(6)

SLRC does not engage in any extraordinary collection actions (ECAs) as defined by Internal Revenue Code §501(r)(6) prior to the expiration of the "notification period." The Notification Period is defined as a 120-day period, which begins on the date of the 1st posted discharge billing statement, in which no ECAs may be initiated against the patient.

Subsequent to the Notification Period, SLRC or any 3rd parties acting on their behalf, may initiate the following ECA against a patient for an unpaid balance if a FAP eligibility determination has not been made or if an individual is ineligible for financial assistance.

1. Referral to a collection agency
2. Deferring, denying or requiring payment before providing medically necessary care because of an individual's non-payment for previously provided care; and
3. Commencing a civil action against an individual

SLRC may authorize 3rd parties to initiate ECAs on delinquent patient accounts after the Notification Period. SLRC will ensure reasonable efforts have been taken to determine whether an individual is eligible for financial assistance under this FAP (Financial Assistance Program). SLRC will take the following actions at least thirty (30) days prior to initiating any ECA:

1. The patient has been provided with written notice which:
    a. Indicates that financial assistance is available for eligible patients;
    b. Identifies the ECA(s) that SLRC intends to initiate to obtain payment for the care; and
    c. States a deadline after which such ECAs may be initiated.

2. The patient has received a copy of the PLS (plain language summary) with this written notification; and
3. Reasonable efforts have been made to orally notify the individual about the FAP and how the individual may obtain assistance with the financial assistance application process.

The 2017 Health & Human Services (HHS) Poverty Guidelines

Source: https://www.gpo.gov/fdsys/pkg/FR-2017-01-31/html/2017-02076.htm

Computations for the
2017 Annual Update of the HHS Poverty Guidelines

Persons in family or household	2017 poverty guidelines (100% of poverty)	130% of poverty	145% of poverty	150% of poverty	185% of poverty	200% of poverty	300% of poverty
1	$12,060	$15,678	$17,487	$18,090	$22,311	$24,120	$36,180
2	$16,240	$21,112	$23,548	$24,360	$30,044	$32.480	$48,720
3	$20,420	$26,546	$29,609	$30,630	$37,777	$40,840	$61,260
4	$24,600	$31,980	$35,670	$36,900	$45,510	$49,200	$73,800
5	$28,780	$37,414	$41,731	$43,170	$53,243	$57,560	$86,340
6	$32,960	$42,848	$47,792	$49,440	$60,976	$65,920	$98,880
7	$37,140	$48,282	$53,853	$55,710	$68,709	$74,280	$111,420
8	$41,320	$53,716	$59,914	$61,980	$76,442	$82,640	$123,960
For each additional person add	$4,180	$5,434	$6,061	$6,270	$7,733	$8,360	$12,540

- Note: The rounding rules for these calculations, as well as procedures for calculating monthly income, are determined by the federal, state, and local program offices that use the poverty guidelines for eligibility purposes.
- These figures are for the 48 Contiguous States and the District of Columbia
- This guide is updated each year.

SOURCE: Federal Register Volume 82, Number 19 (Tuesday, January 31, 2017)

The following programs use the HHS poverty guidelines or multiples of them:

100% - Head Start; Early Head Start
130% - Shared Visions; National School Lunch Program (Free - at or below 130%); Medicaid (133%)
145% - Child Care Subsidy
150% - Low Income Home Energy Assistance Program (LIHEAP); Weatherization
185% - WIC; Title V - Maternal & Child Health Services; National School Lunch Program (Reduced fees - between 130% - 185%)
200% - ECI Low-Income Preschool Tuition Assistance; *hawk-i*;