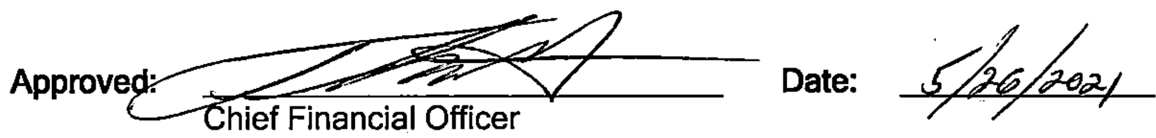
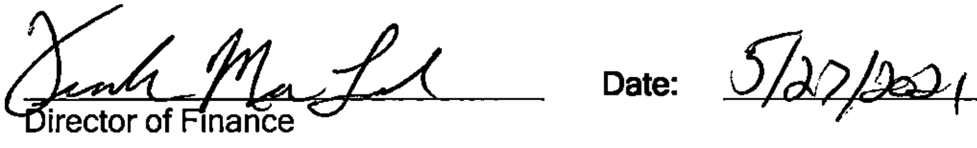
Policy/Procedure Manual: Finance

Subject: Financial Assistance Program & Billing Process **Policy:** #14.32
Date: 7/10/01, 5/10, 11/17, 5/2021
Page: 1 of 6



Approved: Chief Financial Officer **Date:** 5/26/2021



Director of Finance **Date:** 5/27/2021

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 also includes 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.

Poverty Guidelines, 48 Contiguous States (all states except AK and HI)

2021 Annual

Household/ Family Size	25%	50%	75%	100%	125%	133%	135%	138%	150%	175%	180%	185%	200%	225%	250%
1	$3,220	$6,440	$9,660	$12,880	$16,100	$17,130	$17,388	$17,774	$19,320	$22,540	$23,184	$23,828	$25,760	$28,980	$32,200
2	$4,355	$8,710	$13,065	$17,420	$21,775	$23,169	$23,517	$24,040	$26,130	$30,485	$31,356	$32,227	$34,840	$39,195	$43,550
3	$5,490	$10,980	$16,470	$21,960	$27,450	$29,207	$29,646	$30,305	$32,940	$38,430	$39,528	$40,626	$43,920	$49,410	$54,900
4	$6,625	$13,250	$19,875	$26,500	$33,125	$35,245	$35,775	$36,570	$39,750	$46,375	$47,700	$49,025	$53,000	$59,625	$66,250
5	$7,760	$15,520	$23,280	$31,040	$38,800	$41,283	$41,904	$42,835	$46,560	$54,320	$55,872	$57,424	$62,080	$69,840	$77,600
6	$8,895	$17,790	$26,685	$35,580	$44,475	$47,321	$48,033	$49,100	$53,370	$62,265	$64,044	$65,823	$71,160	$80,055	$88,950
7	$10,030	$20,060	$30,090	$40,120	$50,150	$53,360	$54,162	$55,366	$60,180	$70,210	$72,216	$74,222	$80,240	$90,270	$100,300
8	$11,165	$22,330	$33,495	$44,660	$55,825	$59,398	$60,291	$61,631	$66,990	$78,155	$80,388	$82,621	$89,320	$100,485	$111,650
9	$12,300	$24,600	$36,900	$49,200	$61,500	$65,436	$66,420	$67,896	$73,800	$86,100	$88,560	$91,020	$98,400	$110,700	$123,000
10	$13,435	$26,870	$40,305	$53,740	$67,175	$71,474	$72,549	$74,161	$80,610	$94,045	$96,732	$99,419	$107,480	$120,915	$134,350
11	$14,570	$29,140	$43,710	$58,280	$72,850	$77,512	$78,678	$80,426	$87,420	$101,990	$104,904	$107,818	$116,560	$131,130	$145,700
12	$15,705	$31,410	$47,115	$62,820	$78,525	$83,551	$84,807	$86,692	$94,230	$109,935	$113,076	$116,217	$125,640	$141,345	$157,050
13	$16,840	$33,680	$50,520	$67,360	$84,200	$89,589	$90,936	$92,957	$101,040	$117,880	$121,248	$124,616	$134,720	$151,560	$168,400
14	$17,975	$35,950	$53,925	$71,900	$89,875	$95,627	$97,065	$99,222	$107,850	$125,825	$129,420	$133,015	$143,800	$161,775	$179,750

2021 Monthly

Household/ Family Size	25%	50%	75%	100%	125%	133%	135%	138%	150%	175%	180%	185%	200%	225%	250%
1	$268	$537	$805	$1,073	$1,342	$1,428	$1,449	$1,481	$1,610	$1,878	$1,932	$1,986	$2,147	$2,415	$2,683
2	$363	$726	$1,089	$1,452	$1,815	$1,931	$1,960	$2,003	$2,178	$2,540	$2,613	$2,686	$2,903	$3,266	$3,629
3	$458	$915	$1,373	$1,830	$2,288	$2,434	$2,471	$2,525	$2,745	$3,203	$3,294	$3,386	$3,660	$4,118	$4,575
4	$552	$1,104	$1,656	$2,208	$2,760	$2,937	$2,981	$3,048	$3,313	$3,865	$3,975	$4,085	$4,417	$4,969	$5,521
5	$647	$1,293	$1,940	$2,587	$3,233	$3,440	$3,492	$3,570	$3,880	$4,527	$4,656	$4,785	$5,173	$5,820	$6,467
6	$741	$1,483	$2,224	$2,965	$3,706	$3,943	$4,003	$4,092	$4,448	$5,189	$5,337	$5,485	$5,930	$6,671	$7,413
7	$836	$1,672	$2,508	$3,343	$4,179	$4,447	$4,514	$4,614	$5,015	$5,851	$6,018	$6,185	$6,687	$7,523	$8,358
8	$930	$1,861	$2,791	$3,722	$4,652	$4,950	$5,024	$5,136	$5,583	$6,513	$6,699	$6,885	$7,443	$8,374	$9,304
9	$1,025	$2,050	$3,075	$4,100	$5,125	$5,453	$5,535	$5,658	$6,150	$7,175	$7,380	$7,585	$8,200	$9,225	$10,250
10	$1,120	$2,239	$3,359	$4,478	$5,598	$5,956	$6,046	$6,180	$6,718	$7,837	$8,061	$8,285	$8,957	$10,076	$11,196
11	$1,214	$2,428	$3,643	$4,857	$6,071	$6,459	$6,557	$6,702	$7,285	$8,499	$8,742	$8,985	$9,713	$10,928	$12,142
12	$1,309	$2,618	$3,926	$5,235	$6,544	$6,963	$7,067	$7,224	$7,853	$9,161	$9,423	$9,685	$10,470	$11,779	$13,088
13	$1,403	$2,807	$4,210	$5,613	$7,017	$7,466	$7,578	$7,746	$8,420	$9,823	$10,104	$10,385	$11,227	$12,630	$14,033
14	$1,498	$2,996	$4,494	$5,992	$7,490	$7,969	$8,089	$8,269	$8,988	$10,485	$10,785	$11,085	$11,983	$13,481	$14,979

St. Lawrence Rehabilitation Center
Financial Assistance Policy
Plain Language Summary ("PLS")

The St. Lawrence Rehabilitation Center (SLRC) Financial Assistance Policy ("FAP") exists to provide eligible patients with partially or fully-discounted medically necessary healthcare services. Patients seeking financial assistance must apply for the programs offered. The following is a summary of the policy:

Eligible Services - Medically necessary healthcare services provided and billed by SLRC. The FAP only applies to services billed by SLRC. Related services separately billed by other providers, such as independent consulting physicians, may not be covered under the FAP.

Eligible Patients - Patients receiving eligible services who submit a completed financial assistance application ("Application") (including related documentation/information) and who are determined eligible for financial assistance by SLRC.

How to Apply - The FAP and related Application may be obtained/submitted as follows:

- Visiting the SLRC website at www.SLRC.org
- Requesting documents by mail by calling SLRC's Business Office at (609) 896-9500
- By visiting the Admissions Office in person located at 2381 Lawrenceville Road, Lawrenceville, NJ 08648, between the hours of 8:30 AM and 4:30 PM.
- Mail completed Applications (with all documentation/information) specified to:

St. Lawrence Rehabilitation Center
2381 Lawrenceville Road
Lawrenceville, NJ 08648
Attn: Business Office

Determination of Financial Assistance Eligibility - Generally, uninsured patients are eligible for financial assistance. Additionally, underinsured patients may be eligible, using a sliding scale, when their family gross income is at or below 200% of FPG (Federal Poverty Guidelines). Eligibility for financial assistance means that eligible patients will have their care fully or partially discounted and will not be billed more than "Amounts Generally Billed ("AGB") to insured persons (AGB, as defined in IRC §501® by the Internal Revenue Service). Financial assistance levels, based solely on family gross income and FPG, are:

- Underinsured individuals with family gross income at 0 to 100% of FPG; Full financial assistance; $0 is billable to the patient.
- Underinsured individuals with family gross income greater than 100% but less than or equal to 200% of FPG; Partial financial assistance; AGB is maximum billable to the patient.
- All uninsured individuals; Partial financial assistance; AGB is maximum billable to the patient.

NOTE: Other criteria beyond FPG may also be considered (i.e., residency, State program denials), which may result in exceptions to the preceding. If no family gross income is reported, information will be required as to how daily needs are met.

SLRC Business Office Manager or another designee will review submitted applications and determines financial assistance eligibility in accordance with SLRC FAP. If an incomplete application is received, the applicant will be notified and given an opportunity to furnish the required missing documentation/information.

SLRC translates its FAP, Applications and PLS in other languages wherein the primary language of SLRC's primary service area represents the lesser of 5% or 1,000 individuals.
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- Underinsured individuals with family gross income at 0 to 100% of FPG; Full financial assistance; $0 is billable to the patient.
- Underinsured individuals with family gross income greater than 100% but less than or equal to 200% of FPG; Partial financial assistance; AGB is maximum billable to the patient.
- All uninsured individuals; Patient financial assistance, AGB is maximum billable to the patient.

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