

# 870207 Waiver of copayments, coinsurance, deductibles & other patient responsibility payments

Department: Compliance

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General Policy	Exceptions	Documentation needed to show financial hardship	References
<p><i>It is unlawful to routinely waive/fail to collect or discount co-payments, deductibles, coinsurance or other patient responsibility payments per federal false claims act, federal anti-kickback statute, state and federal insurance fraud laws. It is also in violation of our managed care contracts. This includes services deemed as "professional courtesy" and "TWIPS-Take what insurance pays".</i></p> <p><i>Therefore, Esse Health physicians and staff are not to waive or apply a discount to fees deemed to be the patient's responsibility except as outlined under "Exceptions" of this policy.</i></p> <p><i>Anyone found to be in violation of this policy will be subject to corrective action as outlined in the Corrective Action policy.</i></p>	<p><i>The Exceptions to the General Policy are as follows:</i></p> <ol style="list-style-type: none"> <li>1) <i>The entire fee is waived and no insurance carrier is billed any amount for the services rendered</i></li> <li>2) <i>The patient is a self-pay with no health insurance benefits. You may discount care but a consistent office policy will need to be developed.</i></li> <li>3) <i>The patient qualifies for a financial hardship waiver or discount. Documentation of financial hardship must be included in the patient's medical record and a supporting note in the patient's financial account in PEARL. Please reference "Documentation needed to show financial hardship" section on acceptable documentation.</i></li> <li>4) <i>Reasonable efforts have been made to collect on the account. Once patient has gone through the collection phase as set up by Patient Accounts and the amounts are deemed "uncollectable" the amounts can be written off.</i></li> <li>5) <i>The amount of patient responsibility is under \$5 after 120 days of no activity (no new charges/credits) on the account. The Patient Accounts Department and the physician office will determine if the patients will be sent statements during this 120-day cycle.</i></li> </ol>	<p><i>The patient will need to complete a financial disclosure form (see attachment B) and provide documentation of proof of income.</i></p> <p><i>Appropriate documentation of financial hardship would be one or more of the following:</i></p> <ol style="list-style-type: none"> <li>1) <i>Documented proof that patient is at or below 200% of the current federal poverty guidelines (see attachment A for 2000 guidelines)</i></li> <li>2) <i>Patient has other circumstances that indicate financial hardship.</i></li> </ol> <p><i>These can be situations such as proof of bankruptcy settlement, catastrophic situations (death or disability in family, divorce) or other documentation that shows that patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses.</i></p> <p><i>Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.</i></p> <p><i>Any denial of "financial hardship" discount request will be written and will include instructions for reconsideration. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered per the above guidelines.</i></p> <p><i>All information relating to financial hardship requests will be kept confidential.</i></p>	<p><i>OIG Special Fraud Alert (1994)</i></p> <p><i>OIG Advisory Opinion 97-4</i></p> <p><i>Federal Register, Vol 65, No. 81, 4-26-00 pages 24401-24407</i></p> <p><i>42 CFR, section 1001.952 (k)</i></p> <p><i>HIPAA, section 231(h), section 1128A</i></p> <p><i>42 USC, Section 1320a-7a</i></p> <p><i>BBA, section 4331</i></p> <p><i>False Claims Act</i></p> <p><i>Public Law 104-191, Subtitle E, Section 242(a)</i></p> <p><i>Missouri Revised Statutes, Chapter 191, Section 191.905</i></p> <p><i>Kennedy v Connecticut General Life Ins. Co (Case Law) 924 F.2d 698 (7<sup>th</sup> Cir. 1991)</i></p> <p><i>Managed Care Contracts</i></p>

Attachment A

THE 2000 HHS POVERTY GUIDELINES

Based on a page from the Web site of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

The guidelines are a simplification of the poverty thresholds for use for administrative purposes--for instance, determining financial eligibility for certain federal programs.

## Esse Health

### Financial Hardship Discount Information Needed

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2005 Poverty Guidelines for the 48 Contiguous States  
and the District of Columbia  
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Persons in family unit	Poverty guideline
1.....	\$9,570
2.....	12,830
3.....	16,090
4.....	19,350
5.....	22,610
6.....	25,870
7.....	29,130
8.....	32,390

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For family units with more than 8 persons, add \$3,260 for each additional person.  
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**Please provide following information so we may complete your application:**

- MOST RECENT IRS TAX FORMS (1040 AND/OR W-2) (MUST BE SIGNED)
- CHECK STUBS FOR THE PAST 30 DAYS FOR ALL PERSONS EMPLOYED IN THE HOME.
- UNEMPLOYMENT CHECK STUBS FOR THE PAST 30 DAYS.
- DRIVERS LICENSE OR IDENTIFICATION CARD FOR ADULTS.
- PROOF OF ALL OTHER INCOME RECEIVED IN THE PAST 30 DAYS.
- PROOF OF ALL OUTSTANDING BILLS (PAYMENT STUBS, CANCELLED CHECKS, ETC.)
- DSHS DENIAL LETTER.
- MEDICAID FORMS OR CARD
- ATTACHED FINANCIAL STATEMENT (**COMPLETELY FILLED OUT AND SIGNED**)

**PLEASE BE SURE TO SIGN THE ATTACHED FINANCIAL STATEMENT  
YOUR REQUEST WILL NOT BE PROCESSED IF THIS IS NOT SIGNED!**

PLEASE RETURN ALL ITEMS (AS APPLICABLE) ON THIS CHECKLIST (IN PERSON OR BY MAIL)

**ESSE HEALTH  
FINANCIAL STATEMENT  
PAYMENT PLAN/UNCOMPENSATED SERVICES APPLICATION**

PATIENT NAME: \_\_\_\_\_ DATE(S) OF SERVICE \_\_\_\_\_

NAME OF RESPONSIBLE PARTY: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

SPOUSE: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD): \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

IF UNEMPLOYED, HOW LONG?: \_\_\_\_\_

SPOUSE'S EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

IF UNEMPLOYED, HOW LONG?: \_\_\_\_\_

OTHER FAMILY MEMBER EMPLOYER(S): (INCLUDE MEMBER NAME, EMPLOYER, &  
ADDRESS:) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MONTHLY FAMILY INCOME & SOURCE**

	Patient	Spouse	Responsible Party	Children Working
Monthly Salary (Gross)				
Public Assistance Benefits				
Unemployment Benefits				
Social Security Benefits				
Workman's Compensation				
Child Support				
Other (Alimony, Etc.)				

TOTAL FAMILY INCOME \$ \_\_\_\_\_

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE ESSE HEALTH TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

\_\_\_\_\_  
SIGNATURE OF PERSON MAKING REQUEST DATE

\_\_\_\_\_  
SIGNATURE OF SPOUSE/OTHER DATE

.....  
**DO NOT WRITE BELOW THIS LINE – FOR OFFICE PERSONNEL USE ONLY**

This document was received on \_\_\_\_\_ by \_\_\_\_\_  
(date) (Name/Title)

Approved by physician or office manager \_\_\_\_\_  
(signature of physician or office manager)