

## Purpose

Columbus Regional Health (CRH) is committed to providing health care services regardless of a patient's ability to pay. Patients who express an inability to pay and who meet the policy's financial criteria will be covered under the Financial Assistance Policy. The purpose of this policy is to provide detailed information to our patients, Columbus Regional Health staff, and the community regarding services eligible for financial assistance, the application process, and eligibility criteria. This policy is available in both English and Spanish and has been approved by Columbus Regional Health's Board of Trustees.

## Definitions

- A. Amounts Generally Billed (AGB):** 26 CFR Part 1 §1.501(r)-(1)(b)(1) the amounts generally billed for emergency or other medically necessary care to individuals who have insurance coverage.
- B. Medically Necessary Services:** services rendered to a patient in order to diagnose, alleviate, correct, cure, or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in overall illness or infirmity.
- C. Household Income:** The total gross income (before taxes) of all members of a patient's household.
- D. Dependent:** Person must be claimed on taxes as a dependent.
- E. Presumptive Eligibility:** Assistance granted based upon special circumstances at the time of application that proves financial hardship outside of the standard criteria.
- F. Cosmetic Services:** Not medically necessary services that are provided to enhance the patient's well-being and are not typically covered by insurance.
- G. Cash-Only Services:** These are services not billed to insurance and payment is expected in full prior to service being rendered.
- H. Guarantor:** The responsible party for the patient's bill, typically the patient or a parent in the case of a minor.

## Procedure

### A. Communication of Financial Assistance Policy

Information concerning the Financial Assistance Policy, application, and Plain Language Summary is available on the Columbus Regional Health website ([www.crh.org](http://www.crh.org)), on the back of each patient statement, or by calling Patient Financial Services customer service at 812-376-5315 or 1-800-841-4954 (hours 8:00 am to 4:30 pm, Monday through Friday).

## B. Eligible Services

1. The financial assistance policy applies to medically necessary services. Medical necessity is determined by the examining physician.
2. Services that are not eligible for assistance are:
  - Cosmetic services
  - Bariatric surgery
  - Botox injections (unless due to a diagnosis of migraines)
  - Hearing aids
  - Fertility services
  - Physicals and other services required by employment, schools, or athletics
  - Genetic related services and testing
  - Services denied by insurance due to non-compliance from beneficiary and/or patient to respond to insurance requests/requirements
  - Services otherwise reimbursed by another third party (such as part of a motor vehicle accident lawsuit)
  - Services reimbursed directly to the patient/beneficiary by insurance
  - Cash-only services

## C. Eligible Providers

Eligible services provided by Columbus Regional Hospital, Columbus Regional Health Physicians, and Columbus Diagnostic Imaging are covered by the Financial Assistance Policy. All non-employed physicians and other clinical staff and facilities not owned by CRH are not included in the Financial Assistance Policy. A list of excluded providers can be found on the website at [www.crh.org](http://www.crh.org).

## D. Eligibility Criteria

1. Qualification for assistance is based on gross household income and the number of dependents claimed on tax filing for that household, whether filing jointly or individually. (1.501(r)(b)(1)(iii)(A)).
2. Income is compared to the Columbus Regional Health guidelines, which are derived by using the Federal Poverty Guidelines. Income can be up to 350% over the Federal Poverty Guidelines and qualify for assistance. Columbus Regional Health Financial Assistance Policy is in compliance with Federal Regulations 1.501(r).

Patients whose gross family income does not exceed 350% of the Federal Poverty Guidelines are eligible for certain levels of financial assistance.

The current Federal Poverty Guidelines can be found on [www.crh.org](http://www.crh.org).

% of Federal Poverty Level	Approval Threshold
0-200%	100%
201-300%	80%
301-350%	61%

3. Columbus Regional Health reserves the right to use additional criteria to determine eligibility as deemed necessary, such as:
  - Publicly available data sources that provide information on a guarantor's ability to pay, such as credit score
  - Expenses such as mortgage/rent, utilities, child support, food, and other basic living expenses
  - Assets such as checking accounts, savings accounts, and other certificates of deposit
  - Pension accounts, 401k, 403B, IRAs, and other retirement accounts will only be considered if the patient is receiving this as part of their income
  - Columbus Regional Health's payment scoring based on historical payment patterns
4. The patient must exhaust insurance and third-party liability coverage prior to patient receiving financial assistance through the Financial Assistance Policy. The patient must cooperate with pursuing enrollment in all affordable health coverage programs or other state or federal programs that are accessible to them prior to consideration of financial assistance approval. Assistance with the assessment and enrollment is provided by certified Indiana Navigators and Certified Application Counselors free of cost to the patient.

## E. Presumptive Eligibility

In certain situations, it may be appropriate to grant financial assistance even though the patient's financial application does not satisfy the requirements set forth in this policy. In these situations, the financial assistance application as well as other contributing factors may be used to determine a patient's qualification for assistance. A catastrophic event may also be considered as a form of presumptive eligibility whereby the patient's out of pocket amount exceeds 20% of their annual income and the services were of an unexpected and emergent nature, such as an emergency stay or oncology treatment costs. Presumptive eligibility approvals will be made per the discretion of Columbus Regional Health employees and as such, may be for unique time periods or for specific balances.

Other scenarios that may qualify for presumptive eligibility include but are not limited to:

- Medicaid and Healthy Indiana Plan patients with coverage lapses or copays
- Balances remaining prior to the effective date of Medicaid or HIP approval if within 240 days of approval and not placed at a collection agency.
- Patients that are incarcerated

- Patients who are homeless
- Patients that file for bankruptcy once notice of filing has been received from bankruptcy court/attorney.
- Deceased patients. If an estate is opened at a later time CRH will file against the estate and recover funds if possible. Additionally, the surviving spouse may be deemed able to pay balances based on the household income.
- Patients that cannot provide a valid U.S. social security number may be considered for approval.

## F. Application Process

1. Patients may apply for assistance within 240 days of the date of service related to their outstanding balance(s).
2. Once application is provided to the patient, Columbus Regional Health allows up to 30 days for the return of all required information.
3. Patients are provided with complete instructions on how to complete the application and what information is required to be returned with the application.
4. The financial application must be completed, signed and returned for review along with copies of all supporting documents before approval can be made. The address can be found on the application or also listed at the bottom of the policy.
5. Patients are provided with the name and direct telephone number for their financial counselor for any questions or concerns they may have during the application process.
6. Required Documentation for the Application:
  - The application itself, completed and signed
  - Copy of previous year's income tax return (1040 form)
  - Up to last three pay check stubs
  - If the patient did not file taxes due to income level and receives a monthly benefit (social security, disability or unemployment), a copy of the awarded amount must be provided. Acceptable proof of benefit includes a letter showing the amount awarded or a bank statement showing the monthly deposited amount.
  - If the patient did not file taxes for any other reason, this must be documented on the patient file as to why this information cannot be obtained.
  - Since determination is based upon all household income, a spouse/partner as well as any other adult applicants included in the application must also sign the application.

## G. Approval Process

1. Patients will receive a letter to notify them of either an approval or denial of financial assistance. The approval process is typically less than 30 days as long as all required information is submitted.
2. If an applicant has been uncooperative at any time during the insurance billing or financial application process, or knowingly provides incorrect/false information, the assistance may be limited or denied.
3. Financial assistance approvals are valid for 12 calendar months from date of application, unless otherwise noted in the approval letter.

4. Financial assistance approvals will follow the guarantor, not the dependent. This means that the approved guarantor on the financial application will receive financial assistance adjustments for a dependent only if they are listed as the responsible party for that dependent. If a dependent has a different guarantor listed on the account that was not listed on the financial application, that account balance will not be considered for financial assistance adjustment.
5. If financial assistance is denied, a patient may reapply at any time given changes in their circumstances or if the policy changes.
6. Any patient receiving a financial assistance decision will have the right to appeal the decision if they disagree with the determination by submitting a written letter explaining their reason for reconsideration to the address listed below.  
Columbus Regional Hospital  
Attn: Patient Financial Services  
2400 E 17<sup>th</sup> Street  
Columbus, IN 47201
7. Balances that have already been referred to an outside collection agency or established payment plan that are within 240 days of the application date will be considered for adjustment of the current balance only. Adjustment will be the same percentage as the financial application approval and will be taken against the current balance of the bad debt encounter or remaining amount of the payment plan. Refunds will not be made on accounts already placed with a collection agency or that have an established payment plan.
8. The approved percent will be applied to the total patient responsibility portion of their outstanding bill(s).
9. Encounters that have a current active balance with Columbus Regional Health will be reviewed for possible refund of patient payment if it is deemed the approved assistance is greater than what the patient already paid. Payments on balances already adjusted off to Bad Debt are excluded from refund consideration.

## H. Actions in the Event of Non-Payment

In the event of non-payment on remaining balances after financial assistance and any other discounts, patients will proceed through the collections process as with any outstanding balance owed.

## I. Amounts Generally Billed

Per Treasury Regulations §1.501(r)-5(a)(1), a hospital must limit the amount charged for care provided to any individual who is eligible for assistance under its financial assistance policy to not more than amounts generally billed (AGB) in the case of emergency and other medically necessary care. Columbus Regional Hospital calculates an AGB percentage based on the look-back method and is based on actual claims paid. In accordance with §1.501(r)-5(b)(3)(i), AGB percentage is based on the Medicare fee-for-service and all private health insurers that pay claims to the hospital facility.

The AGB is calculated annually by dividing the sum of the amounts of all of its claims for emergency and other medically necessary care that have been allowed by Medicare and Commercial insurers during a prior 12-month period by the sum of the associated gross charges for those claims. Amounts Generally Billed information specific to the current period can be found on the website at [www.crh.org](http://www.crh.org).

## J. Columbus Regional Health Contact Information

For further information or questions regarding this policy, please contact us at:

1. **By phone:** Call Patient Financial Services at 812-376-5315 or toll free at 1-800-841-4954
2. **By mail:**  
Columbus Regional Hospital  
Attn: Patient Financial Services  
2400 E 17<sup>th</sup> Street  
Columbus, IN 47201
3. **On MyChart:** Or by sending a secure message through MyChart at [mychart.crh.org](http://mychart.crh.org) under “ask a question” related to bill or statement.