

UNIVERSITY OF ILLINOIS MEDICAL CENTER AT CHICAGO MANAGEMENT POLICY AND PROCEDURE

NO.: LD 3.07

DATE: November 2009

SUBJECT: Uninsured (Self-pay) Patients – Charity Care

OBJECTIVE

To define a charity assistance policy specifying how the University of Illinois Medical Center at Chicago (the Medical Center) will determine the financial liability for medically necessary services rendered to financially qualified uninsured patients and to specify how the Medical Center will determine and apply uninsured discounts for services provided to financially qualified uninsured patients.

DEFINITIONS

For the purpose of this policy, the following definitions apply:

Charity care: Medical care for which the likelihood of payment of charges in full from patient, family or third party source is not anticipated.

Uninsured patient: A patient who is a legal resident of the United States, who does not have third-party coverage from a health insurer, a health care service plan, Medicare, or Medicaid, and whose injury is not compensable for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. The term does not include any patient who had an opportunity to obtain third-party coverage through his or her employer but did not obtain such coverage.

Elective self pay patient: A patient with insurance who requests to receive non-emergent or non-urgent medical care outside of insurance plan coverage limitations, or who otherwise requests to be billed at charges directly for non-emergent medical care services.

Medically necessary service: Any inpatient or outpatient hospital service that is covered by and considered to be medically necessary under Title XVIII of the federal Social Security Act. Medically necessary services do not include any of the following: (1) Non-medical services such as social, educational, and vocational services. (2) Cosmetic surgery.

Emergency medical care: Medical care which (in the professional judgment of the applicable physician), if not rendered, would result in a serious threat to health, risking the occurrence of a significant disability or loss of life (within 24 hours).

Urgent medical care: Medical care needed for a condition that does not require emergency medical care, but for which, based on medical appropriateness, treatment must be provided within 24 hours to prevent worsening of the patient's condition.

Financial Plan: Any one or a combination of the following to assure payment of charges:

- Adequate and verifiable insurance or other third party coverage assigned to the Medical Center by an authorized person;
- A guarantor of account acceptable to the Chief Financial Officer, or designee;
- The willingness of the patient and/or family (or representative) to apply for medical assistance programs (including grants and other sources of funding);
- A satisfactory repayment agreement by the patient, family and/or representative to pay Medical Center charges;
- Review and approval of eligibility for charity care, in whole or in part.

Uninsured discount: With respect to medically necessary services rendered to a financially qualified uninsured patient, a discount that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

Non-emergent medical care: Medical care which (in the professional judgment of the applicable physician), if not rendered, would present neither serious threat to a patient's health nor risk the occurrence of significant disability or loss of life.

Financially qualified uninsured patient: A patient who is uninsured, whose family income is less than 400% of the federal poverty level, and who satisfies the requirements under a hospital's charity assistance policy under the Patient Responsibilities section of this policy.

Federal poverty level: The poverty guidelines which are updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

Charges: The level of billing for services that the hospital sets in order to allow its revenue budget to exceed its expense budget, given payment by many payers at levels insufficient to recover full costs for those payer's patients. Charges include co-pays and deductibles.

POLICY

Elective self-pay patients will only be considered for charity care if:

- The treatment/services requested fulfill the research/teaching mission of the Medical Center and/or
- The specialized care required is only available at the Medical Center.

Consideration for eligibility of charity care will be based on application of the following criteria:

- The patient is an uninsured patient as defined by this policy; and
- The patient is financially qualified uninsured as defined by this policy; and
- The patient is receiving, scheduled to receive, or has received a medically necessary service as defined by this policy; or

- A determination is made on individual cases by any external vendor or income scoring program contracted for the purpose of evaluating cases for charity care; or
- The patient qualifies for funding under Section 1011 (CMS) program and an unpaid balance remains for services not fully funded by the program.

Charity care assistance will generally be provided on a prospective basis unless there is evidence of a pending application for public aid and/or social security disability coverage at the date of application.

The Chief Financial Officer will establish requirements related to qualifications for application and related discounts under charity care. The Patient Accounts Department shall be responsible for implementing the policy according to the requirements.

The University of Illinois Medical Center at Chicago is committed to assisting Patients in further understanding Financial Policies and in application for potential third party programs to offset the costs related to medically necessary services, see [MCMPP LD 1.01 Mission Statement – University of Illinois Medical Center at Chicago](#). The Medical Center will provide Financial Counselors to assist the patient in completing the application process for the program the Patient is best suited. This includes assisting patients in completing the Charity Care application process.

Charity care eligibility will be approved for a maximum of one year from the date of application at which time the patient must provide updated financial information for review to continue eligibility.

All discounts as described by this policy only apply to services billed by the hospital. Most physician services are not included in this policy.

The Medical Center will make available, upon request by a member of the public, a copy of the application used by the Medical Center to determine a patient's eligibility for charity care.

Notwithstanding any requirements of this policy, individual uninsured cases may be considered for charity at the sole discretion of the Chief Financial Officer or designee.

Patient responsibilities:

This policy requires the cooperation of the uninsured patient as a condition of receiving assistance; see [MCMPP RI 1.01 Rights and Responsibilities of Patients](#). That cooperation includes, but is not be limited to, the following:

- The uninsured patient must cooperate with the Medical Center by providing information on third-party coverage. If the Medical Center finds that there is a reasonable basis to believe that the patient may qualify for such assistance, the patient must cooperate in applying for third-party coverage that may be available to pay for the uninsured patient's medically necessary care, including coverage from a health insurer, a health care service plan, Medicare, Medicaid, KidCare, FamilyCare, automobile insurance, worker's compensation, or other insurance.

- The uninsured patient must provide the Medical Center with financial and other information requested by the Medical Center to determine eligibility for charity assistance through the Medical Center. Generally, information to support application materials must be received within 60 days of the initial charity application request.
- Generally, the uninsured patient or a person acting on his or her behalf must request assistance from the Medical Center. Although, the Medical Center has full discretion to identify specific cases for potential charity needs based on financial and other information available to the Medical Center.
- The uninsured patient who has a payment obligation to the Medical Center must cooperate with the Medical Center to establish and comply with a payment plan. The uninsured patient who enters into a payment plan with the Medical Center shall promptly inform the Medical Center of any change in circumstances that will impair his or her ability to comply with the payment plan.
- The uninsured patient must meet with a Financial Counselor on an annual basis to review his/her current financial status for continued eligibility on charity care.
- The uninsured patient must notify the Medical Center of any change in financial status that could disqualify the patient for charity care assistance.

An uninsured patient who fails to satisfy his or her responsibilities under the Patient Responsibilities section of this policy may be billed by the hospital and is subject to collection activities consistent with the hospital's billing and collection policies and practices for patients who do not qualify for assistance under its charity assistance policy. A financially qualified uninsured patient who fails to comply with a payment plan may be billed by the hospital and is subject to collection activities consistent with the hospital's billing and collection policies and practices for the portion of the bill remaining after the uninsured discount has been applied.

Billing:

The Medical Center must make reasonable efforts to obtain from a patient or his or her representative information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the Medical Center to the patient, including, but not limited to, any of the following:

- Private health insurance.
- Medicare.
- Medicaid, FamilyCare, KidCare, or other state-funded or county-funded programs designed to provide health coverage.

If an uninsured patient complies with a payment plan that has been agreed to by the Medical Center, the Medical Center shall not otherwise pursue collection action against the uninsured patient.

If an uninsured patient has requested charity assistance from the Medical Center and is cooperating with the Medical Center under the Patient Responsibilities section of this policy, the Medical Center or its assignee or billing service shall not pursue any collection action against the uninsured patient until a determination is made on the uninsured patient's eligibility for charity assistance.

Notification

The Medical Center, upon request, will provide any member of the public and the regulatory agencies with a copy of its charity care policy. In addition, information about financial assistance and contact information will be made available in all registration areas through signage and brochures.

Denial of non-emergent services

In the event that a physician, due to his/her professional assessment of the patient's medical condition, disagrees with the denial of non-emergent services, based on inability to establish a financial plan or non-adherence to an established plan under this policy, the case will be referred for review and final disposition to the Chief Medical Officer, in consultation with the Chief Financial Officer and any others he/she deems appropriate.

Waiver of Fees

Individual physicians, including those in the University of Illinois at Chicago Medical Service Plan, may waive their own professional fees, but may not waive and have no authority to waive the professional fees of other licensed professionals or facility fees of the Medical Center.

PROCEDURE

I. Non-emergent inpatient and Surgicenter Admissions

- A. The registrar will determine patient financial status (including the presence of an existing financial plan) during the pre-admission registration/verification process.
- B. If the patient is uninsured (self-pay), the patient will be informed of the admission deposit requirement and other alternatives. The full deposit amount is required no later than 7 days prior to the admission/procedure date.
- C. If the patient is unable to pay the entire deposit amount 7 days prior to the admission/procedure date, and does not already have a financial plan, he/she will be referred to a Financial Counselor to develop a financial plan. Once the plan is determined, the Financial Counselor will inform the admitting staff.
- D. If the patient declines to develop a financial plan:
 1. Patient Accounts will inform the admitting staff.
 2. The admitting staff will notify the admitting/attending physician.
 3. The admitting/attending physician will:
 - a. Provide the patient with information about alternative treatment sources/options outside the Medical Center. (Routine collection procedures will be followed to obtain compensation for services rendered.) or
 - b. Appeal the case to the Chief Medical Officer.

II. Non-emergent Outpatient Procedures and Office Visits

- A. The scheduler/registrar will determine patient financial status (including the presence of an existing financial plan) at the time of scheduling.
- B. If the patient is self-pay, the patient will be informed of the deposit on account

- amount. The deposit is required at the time of service.
- C. If the patient is able to pay only a portion of the deposit amount at the time of service, and does not already have a financial plan, he/she will be referred to a Financial Counselor to develop a financial plan.
 - D. If the patient is unable to pay any of the deposit amount at the time of service, the procedure/visit will be rescheduled after consultation with the physician. However, if, in the clinical judgment of the physician, the visit must proceed due to continuity of care or other medical necessity, the visit will occur as scheduled, and he/she will be referred to a Financial Counselor to develop a financial plan.
 - E. If the patient declines to develop a financial plan, the physician will be informed and the admitting/attending physician will provide the patient with information about alternative treatment sources/options outside the Medical Center. Routine collection procedures will be followed to obtain compensation for services rendered.

Rescission

March 2007

December 2004

Reference

University of Illinois Medical Center at Chicago,

Medical Center Management Policy and Procedure Manual,

[LD1.01 Mission Statement – University of Illinois Medical Center at Chicago](#)

[RI 1.01 Rights and Responsibilities of Patients](#)

Patient Accounting Department Policy and Procedure Manual,

CHARITY-1 - Charity Care Qualifications, Charity Discounts, Catastrophic Loss Claims, Section 1011 Program, External vendor reviews

Policy Owner—Marc DeVar, Director, Senior Revenue Cycle Director