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DEPARTMENT: Davis Health System Fiscal Services	POLICY DESCRIPTION: Financial Assistance Policy
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POLICY: Financial Assistance

In accordance with Davis Health System’s stated mission to provide patient-friendly, quality health care to its communities, it is the policy of DHS to offer financial assistance for **medically necessary care** (see Exclusionary services listed on Exhibit III and/or may be obtained by contacting a Financial Assistance Advocate at 304-637-3125) to those persons who are truly indigent and qualify financially based on applicable Federal Poverty Income Guidelines distributed by the Department of Health and Human Services. Davis Medical Center (DMC), Webster Memorial Hospital (WMH) and Broaddus Hospital (BH) are not for profit facilities committed to providing emergency and medically necessary, high quality healthcare services regardless of our patients’ ability to pay. The hospitals acknowledge that there are patients in our communities who do not possess the ability to pay for emergent or medically necessary healthcare services. This Financial Assistance Policy outlines the Policy and Procedures around obtaining financial assistance for these bills.

PROCEDURE:

Eligibility determination is made based on completion of the following requirements. Davis Health System reserves the right to extend Financial Assistance in exceptional circumstances outside of the guidelines listed below. Davis Health System also reserves the right to amend or reverse the guidelines at any time. A list of providers can be found at www.davishealthsystem.org/find-a-provider, the details section of each provider will state if the provider is not covered by the financial assistance policy.

A separate Billing and Collection Policy (**FC 1.12**) outlines the process DHS Hospitals will go through to collect outstanding bills. A copy of the Billing and Collection Policy can be obtained at www.davishealthsystem.org, or by calling Davis Medical Center patient financial services at 304-637-3125, Webster Memorial Hospital via the Patient Advocate at 304-847-5682 ext. 6007, or Broaddus Hospital patient financial services at 304-457-8123.

POLICY:

A. Eligibility Criteria

- a. Income Threshold: Full Financial Assistance will be provided to those patients where the adjusted gross household income from the patient's federal tax return is at or below 300% of the federal poverty guidelines as published annually by the Community Services Administration in the Federal Register (Exhibit II) and where there are not substantial assets.
- b. Bankruptcy Cases: Bankrupt patients may be considered for Financial Assistance upon receipt of bankruptcy notice. A Proof of Claim must be filed, except when the bankruptcy notice indicates that there are no assets from which any dividend can be paid.
- c. Long Term & Catastrophic Illness: Patients not otherwise eligible, but who are financially needy as a result of long-term catastrophic illness, may be considered for a Charity Care Adjustment. Long-term catastrophic illness is any illness or injury that will likely require continuous or frequent treatment for more than one year, with the patient being liable for initial care up to two times their annual adjusted gross income.

B. Program Requirements

- a. Residency Requirement: The Financial Assistance program is designed for West Virginia residents. Financial Assistance will also be considered for out of state residents who arrive in our emergency room via ambulance or air ambulance and for out of pocket expenses when the patient carries third party insurance through commercial or government sources.
- b. Medicaid (Medical Assistance) Application Requirement: Financial Assistance will be denied to patients who refuse to take reasonable actions necessary to obtain medical assistance available through outside health and welfare agencies, when referred by the Financial Counselors or third party vendor. This may include working with an outside agency contracted by DHS to assist patients with government programs. Documentation in the form of a denial letter from West Virginia Medicaid or from the Medicaid program in the state of residence, or chart notes/denial letter from the outside contracted agency indicating the reason for the Medicaid denial is required. This documentation must be dated within the last 90 days and sent with the Financial Assistance application.
- c. Current Patient Requirement: Applications will be issued to a patient with a current balance, a scheduled appointment or a patient in need of financial clearance prior to obtaining an appointment.

C. Assistance Levels

- a. DHS offers reduced care to individuals in accordance with the Charity Income Guidelines and the above Financial Assistance eligibility criteria.
- b. Amounts Generally Billed (AGB): Individuals not meeting the criteria listed above, but who have no third party coverage (governmental or commercial) will be eligible for discounted care. The discount is an estimate of *Amounts Generally Billed (AGB)* to Commercial and Medicare patients. A discount of 30% will be applied to all hospital charges billed by DHS.
- c. DHS uses the AGB (Amounts Generally Billed) “look back” method as a basis for calculating amounts charged to patients. This method determines the amounts generally billed (AGB) to individuals who have insurance covering emergency or other medically necessary care delivered at its hospitals. The AGB percentages were calculated using all claims allowed by both private pay insurers, including Medicare Advantage, and traditional Medicare, for inpatient and outpatient services having discharge dates within the same 12 month calendar period. Total expected payment from allowed claims during this timeframe was divided by the total billed charges for the same claims. The AGB percentages will be updated annually. Patients determined to be eligible for financial assistance will not be charged more than AGB for emergency or other medically necessary care. Eligible patients with insurance coverage will not be personally responsible to pay more than AGB after all payments by the health insurer have been applied.

D. Distribution of Financial Assistance Policy - Information regarding Financial Assistance will be available:

- a. Through our website: <http://www.davishealthsystem.org> or www.wcmhvw.org by calling our Financial Counselors at Davis Medical Center (304) 637-3125, 304-637-3637, 304-637-3728 and Broaddus Hospital 304-457-8123, or the Patient Advocate at Webster Memorial Hospital 304-847-5682 ext. 6007
- b. At patient access points and upon admission and/or discharge from the facility in plain language publications
- c. Through postings in public areas of the facility (including admission areas, waiting rooms, and emergency room)
- d. On billing statements and/or appointment letters
- e. Through in person and telephone conversations regarding bill payment
- f. Other means that make the policy available to our patients and our community at large.

PROCEDURE

A. Requesting an Application

- a. Existing patients with a current balance, scheduled appointments, or patients in

need of financial clearings prior to obtaining an appointment can find Financial Assistance Applications from the following sources:

1. Our Davis Health System website: <http://www.davishealthsystem.org> or www.wcmhvw.org
2. By calling the Davis Medical Center Financial Counselors at 304-637-3125, Webster Memorial Hospital Patient Advocate 304-847-5682 ext. 6007, or Broaddus Hospital Financial Counselors at 304-457-8123.

B. Inpatient Application Procedure

- a. Private-pay patients and any patient with a liability after third party coverage who indicate an inability to pay are required to complete a Financial Assistance Application Form (Exhibit I). This may include working with a DHS Financial Counselor or an outside agency contracted by DHS to assist patients with government assistance. If there is no third party coverage available and the patient is unable to complete the Financial Assistance Application Form or provide the required verification prior to discharge, the patient should return the application within 30 days. Completed Financial Assistance Application Forms are submitted to the Patient Financial Services/Patient Access Department for review and evaluation.

C. Outpatient Application Procedure

- a. The clinic interviewer refers patients who indicate an inability to pay to a Financial Counselor for third party referrals. If there is no third party coverage available, the patient is referred to a Financial Counselor or an outside agency contracted by DHS to assist patients with government assistance. If government assistance has been denied, the patient is given a Financial Assistance Application Form to complete. Applications should be returned within 30 days.
- b. Completed Financial Assistance Application Forms are returned to the Patient Financial Services/Patient Access Department for review and evaluation.

D. Application Procedure During the Billing Process

- a. Patients will be screened electronically for possible Financial Assistance eligibility prior to accounts being placed in the primary bad debt cycle. If the screening indicates probable financial assistance eligibility based on set criteria, the patient account will be presumed to be Financial Assistance eligible and will be handled as indicated under section G - Financial Assistance Account Adjustments. However, presumptive financial assistance will only apply to the account in question and will not apply for future encounters. A full application will need to be submitted in order to determine eligibility for financial clearance purposes.

- b. While every effort is made to identify those patients eligible for Financial Assistance upon admission or outpatient registration, it is ultimately the patient's responsibility to make arrangement for settlement of their bill. Patients who call or write to the Patient Financial Services Department indicating an inability to pay are sent a Financial Assistance Application Form to complete and return to the Patient Financial Services/Patient Access Department within 30 days.
- E. Incomplete Applications
- a. If an incomplete application is received, the patient will be notified in writing of the missing information and/or documentation that is needed, along with information on the policy. The patient will also be notified that the collection actions will continue if the information is not received within 30 days.
- F. Application Evaluation Procedure
- a. Financial Assistance requests must have a Financial Assistance Application Form (Exhibit I) completed and submitted to the Patient Financial Services/Patient Access Department for evaluation. All required verification/documentation must accompany the application. Failure to comply may result in a denial of Financial Assistance.
 - b. Financial Assistance Applications will be reviewed and evaluated by one or more of the following personnel: Director/Managers/Supervisors of Patient Financial Services/Patient Access; Financial Counselors/Insurance Claims Specialists.
 - c. Household Adjusted Gross Income from the applicant's Federal tax return will be used to determine whether the applicant meets the current income/asset guidelines (Exhibit II). These criteria have been modified to more closely duplicate the requirements used in programs available through Healthcare Reform. If the patient has not filed a Federal tax return, gross income documented on pay stubs or income letters from the most recent 30 day period will be used.
 - d. For the purpose of reviewing a Hospital Financial Statement for Financial Assistance, the following will apply:
 - 1. Member of the Household: Will include all persons currently claimed on the Federal Tax Return. In the event no Federal tax return is filed, DHS reserves the right to verify filing with the IRS.
 - 2. Monthly Income: Monthly income will include all wages, self-employment, Social Security, pension, dividends, interest, rental income, unemployment and/or workers' compensation income.
 - 3. Medical Expenses: The applicant may provide detail of medical expenses to non-Davis Health System hospitals and medical providers. This information may be used to help offset monthly income.
 - 4. Employment of Household Members: Will include all forms of

- employment, including self-employment, for every household member.
5. Property Assets: All property including second home, mobile home, vehicles, lands, campers, boats, motorcycles, stocks, bonds and CDs.
 6. Insurance: Documentation of all medical insurance coverage or if insurance was offered but declined documentation from the employer supporting your reason for declining. If the patient has applied for coverage through the [Healthcare.gov](https://www.healthcare.gov) insurance marketplace, but have elected not to purchase the coverage, the patient should provide a print out from the website indicating the amount of the monthly premium.
 7. If cash convertible assets equal an amount double or more than double the patient portion of the DHS bill, applicant is not eligible for assistance. If substantial hard assets exist, they will also be considered.
 8. Applicants for Financial Assistance will be notified in writing of the approval or denial within 30 days of receipt of a completed application.
 - i. An applicant may appeal a denial and request a re-evaluation which will be processed as outlined in the appeal procedure. Upon denial of Financial Assistance, the patient will be responsible for immediate arrangements for the balance due, to prevent collection activity, including but not limited to internal dunning procedures, reporting of a delinquency on a credit record and legal action.
 9. If an applicant is found to have withheld information requested in the Financial Assistance Application or given false information, an approved or pending Financial Assistance adjustment may be reversed or denied.
 10. If a Financial Assistance adjustment is reversed on a patient account, the balance will be due immediately.
 11. Davis Health System may grant approval or denial based upon each facility's decision.

G. Financial Assistance Account Adjustments – Approved Applications

- a. If a patient has made payments on an account and are subsequently approved for Financial Assistance, any payments made for the account balance that initiated the application will be refunded to the patient. Balances paid for prior dates of service will not be refunded.
- b. If a patient is approved for Financial Assistance after DHS Hospitals engaged in Extraordinary Collection Actions (ECAs), the hospital will take reasonable measures to reverse such actions (e.g. reported to credit reporting agency, wage garnishments, judgments, and liens).
- c. Retrospective Adjustments:
 1. Patients who were not eligible for Medicaid at the time of service, but become eligible for Medicaid within 12 months of the date of service will

- be eligible to have balances adjusted for Financial Assistance.
2. Once charity is approved prior unpaid balances will be considered for Financial Assistance. Patients who are on an active payment plan and apply and meet charity guidelines will have remaining payment plan balance adjusted as Financial Assistance.
 - d. Subrogation: Patients will be required to assign or pay, to the Hospital, all insurance payments or liability settlements received for medical expenses. Payments received on an account with a Financial Assistance adjustment will be applied to the account and the adjustment reversed up to the amount of the Financial Assistance adjustment.
 - e. Credit reports or personal property tax records may be used to confirm information provided on the application and may be part of the basis for our decision.
 - f. Special Financial Assistance: Consideration for the following circumstances will be reviewed on an individual basis:
 1. Bankruptcy
 2. Welfare non-covered inpatient days
 3. Welfare spend down amounts that the patient would owe before Welfare will pay
 4. Medicare non-covered inpatient days
 5. Deceased patients leaving no estates

H. International Patient

- a. All international patients applying for Financial Assistance will be required to provide written documentation of legal entry into the US and evidence that the patient meets self-pay criteria.
- b. An international patient is defined as a non-U.S. citizen who is not eligible to participate in Medicaid or Medicare.
- c. International patients are self-pay accounts and are processed according to self-pay account processing.
- d. In order to determine if an international patient is a candidate for treatment under these guidelines the Financial Counselor will forward all relevant and required information provided to the Director, Patient Accounts/Patient Access to determinate eligibility.
- e. No Financial Assistance will be available to international students or any family member accompanying them due to the fact that they are required to carry medical coverage while attending school. Students will be considered for financial assistance for out of pocket expenses if the patient is covered by a third party carrier.
- f. Once determination is made that the international patient is eligible for Financial

Assistance the Financial Counselor will work with the patient and/or their liaison to ensure they are given a full understanding of their financial liability for the requested service. Financial counseling will be completed upon request at the earliest opportunity prior to service to assist in the identification of alternative funding sources for financial resolution

I. Appeal Procedure

- a. If a Financial Assistance applicant is denied, the applicant may appeal the denial and request a re-evaluation.
- b. The appeal must be submitted in writing within 30 days of the denial date.
- c. Upon receipt of a written appeal to a Charity Care Adjustment denial, the applicant's Financial Statement will be re-evaluated by one of the personnel authorized to review and approve/deny an application who was not involved in the initial evaluation. A written response of approval or denial will be issued within 20 days of receipt of the appeal. If the applicant for a Financial Assistance is denied on an appeal and the applicant still disputes the decision, the applicant must submit a second appeal within 30 days of the date of the second denial. This will be the final appeal accepted from the applicant.
- d. The final appeal will be evaluated by two (2) of the designated personnel authorized to approve/deny a Financial Assistance application. Their evaluation will be completed within 20 days of receipt of the appeal and a detailed, written response will be sent to the applicant outlining the reason(s) for the approval/denial.

EXHIBIT III

NON-COVERED SERVICES

- Joint Replacement
- Cataract
- Sterilization (Vasectomy, Tubal Ligation)
- Tubal/Vasectomy Reversals
- Sleep Lab
- Exploratory Arthroscopy
- Non Emergent T/A
- Fertility Testing/Treatment (i.e., HSG, Semen Analysis)
- Non Emergent MRI
- Labor/Delivery
- Pregnancy
- Routine Exams/Screenings
- Pap Tests
- Mammography
- Colonoscopies
- MVA Related
- Dental Procedures
- Allergy Serum/Drops/Testing
- Swing Bed
- Long Term Care/Mansfield Place
- Cosmetic Procedures (Botox, Juvederm, etc)
- Weight loss visits
- Preventative Care
- Podiatry Services
- Non-Life Threatening STD Treatment
- Nasal/Septal Deviation
- Pain Management Services
- Rural Health Clinic Services

APPENDIX 1

For providers covered under the FAP see the following documents on our website:

- WHM FAP Provider List
- DMC FAP Provider List
- BH FAP Provider List