FINANCIAL HARDSHIP POLICY

Effective August 2018, updated August 2020

POLICY

1. NSM will bill for all applicable out-of-pocket amounts due from our clients and will make good faith efforts to collect such amounts unless the insurer or governmental agency approves otherwise.

2. We will not routinely:

    a. Use financial hardship as a means to avoid charging patients copayment obligations.
    b. Collect coinsurance and deductibles only where the patient has Medicare or other supplemental insurance coverage.
    c. Charge Medicare beneficiaries higher amounts than those charged to other persons for similar services (e.g. to offset the waiver of coinsurance and deductible amounts).
    d. Fail to collect coinsurance and deductibles from selected patients, such as those serviced by certain doctors, for reasons unrelated to indigence or managed care contracting.

3. We may agree to waive or reduce coinsurance and deductible amounts owed by patients who demonstrate a financial hardship; however, all such agreements should be reviewed by the Director of Compliance, or their designee.

4. It is our Policy that patients who are potentially eligible for financial assistance will be evaluated at their request according to our income eligibility guidelines. Further, the level of financial assistance for healthcare services will be determined based on the Federal Poverty Guidelines and/or a demonstrated hardship that would cause a client to be unable to meet basic living expenses if a payment is collected. Applicable intake and determination documentation will be maintained and will exhibit appropriate and consistent application of eligibility guidelines.

5. We will work within the terms and conditions set forth by the patient's third party payer (i.e. Medicare, private insurance company) when offering copayment reductions or waivers to patients.

6. It will not be considered a waiver or reduction when a coinsurance or deduction is forgiven or written off after and as long as we have made a reasonable effort to collect the payment of the deductible or copayment.

7. We will not consider non-covered or denied items as eligible for a waiver or discount. Upgrades that are necessary to meet a clear clinical need when that need cannot be met with existing options may be considered for waiver, if the requirements of the Upgrade Policy are met.

8. When a client qualifies for a discount, not a full waiver, the reduced amount due will be calculated based on the most current benefits verification. When the claim is paid, we will accept the amount approved and adjust any additional balance. If the EOB shows a refund is due the client, though, the overage will be refunded to the client.

9. Applications for waiver or reduction are to be submitted prior to delivery of equipment. Any post-delivery requests may only be considered if there is a documented catastrophic situation that leaves the client unable to pay their balance due.

WHY DO WE HAVE THIS POLICY?

This Policy is intended to establish criteria to determine the appropriateness of reducing or waiving charges for equipment and services provided by NSM.

Most patients' health benefits are covered by private health insurance, state or federal health care programs. These programs may place an out-of-pocket expense obligation on their patients, usually called a coinsurance or deductible. The waiver of a copayment or deductible amount is generally prohibited by federal and state Anti-Kickback statues and the False Claims Act; federal enforcement efforts for violations may include the infliction of civil monetary penalties, as well as exclusion from participation in federal programs and possible civil and criminal liability.

There are several concerns that an organization must consider when deciding whether to grant a reduction or waiver. Every time an organization waives a patient's copayment or deductible, the organization is misrepresenting the actual charge of that service or supply. Therefore, when the service is billed, and the copayment is waived, the federal reimbursement rate to the organization for the service will be more than it should be. The waiver of a copayment or deductible can also be seen as remuneration, as it may influence a patient's choice in picking a provider or be used to refer patients illegally. Additionally, where an organization consistently waives coinsurance, copayments and deductibles for medical services, such actions may foster excessive and inappropriate utilization of healthcare services, deplete scarce resources for indigent care and education, and violate contractual agreements with third party payers. As such, federal regulations set forth safe harbors for the limited and specific circumstances under which it is permissible to waive or reduce a patient's responsibility to pay coinsurance, copayments or deductibles for the provision of medical services. NSM policy is intended to follow those guidelines.

PROCEDURE

1. Waivers or reductions of Medicare copayments and/or deductibles as well as benefits provided to Medicare beneficiaries are prohibited unless provided in accordance with the Determination of Financial Need process outlined below and approved by the Director of Compliance, or their designee.

2. The decision to reduce or waive any coinsurance and/or deductible amounts owed by a patient shall be made on a case-by-case basis and the reasons for the decision shall be documented.

3. The Director of Compliance, or their designee, will review the reduction or waiver decision to ensure that it complies with NSM rules and obligations.

4. Should the Director of Compliance, or their designee, determine that the client does not meet the guidelines and the Application is denied, the Regional Vice President may present an appeal to the Director of Compliance. The Director will present the appeal to the Compliance Committee for a decision. The decision of the Compliance Committee is considered final.

5. Reduction or Waiver of copayments or deductibles should only be allowed if reasonable efforts to collect the copayments or deductibles directly from the patient have failed and the waiver is:
    a. Not advertised;
    b. Not routinely offered; and
    c. Made after a good faith assessment of financial need.

6. The patient's inability to pay must be documented if a waiver is granted.

7. The signed application and all supporting documents must be scanned into the applicable work order and must be titled "FHW Application". A request for review must be emailed to Compliance@nsm-seating.com once the application is scanned; financial documents should not be attached to the email.

8. The Director of Compliance shall semi-annually review, in cooperation with financial management, the list of waivers of copayments to ensure that the policies on this subject are strictly adhered to by management. A report of findings shall be made to the Compliance Committee, along with any recommendations for corrective actions or program improvements.

DETERMINATION OF FINANCIAL NEED

Decisions to reduce or waive charges will be made on a case-by-case basis. To ensure that decisions are appropriately documented and based upon uniform objective criteria, each patient who desires reduction or waiver of any charges must complete the confidential Financial Hardship Application and submit the completed worksheet, together with copies of supporting documents, to their local branch or funding staff member. The client must have been offered the opportunity to secure financing through Care Credit and received a denial or their own credit card, which must be documented on the form. If a client is unable to apply for Care Credit or other funding due to financial circumstances such as bankruptcy, the reason must be listed on the application. Once the application is scanned, the NSM employee must then submit the work order number, not the full application, along with a request for a review, to the Director of Compliance at Compliance@nsm-seating.com. The information on the Application will be compared to our policies to determine eligibility for reducing charges.

NSM reserves the right to modify the criteria considered for waiver or reduction without notice. NSM reserves the right to decline to grant waivers or reductions without explanation.

Criteria considered to determine financial hardship:

1) Documented proof that patient is at or below the current federal poverty guidelines. This can include documents such as:

a. W-2 or unemployment check stub/statements for the past 90 days
b. Most recent check stub/statement for all persons employed in the household
c. Proof of other income received in the past 90 days
d. Forms/letters from employers or assistance agencies
e. Income tax return
f. Forms from Medicaid or other State-funded medical assistance

2) Patient has other circumstances that indicate financial hardship. These can be situations such as:

a. Proof of outstanding debts or bills (copies of statements, late notices, etc.)
b. Proof of bankruptcy, if applicable
c. Evidence of catastrophic situations (death in family, divorce) or other documentation which demonstrates being unable to pay and still be able to pay for basic necessary expenses

3) Patient has applied for Care Credit or other personal credit but does not qualify.

FINANCIAL HARDSHIP APPLICATION FORM

The current form is available on WNSM.

REVISION HISTORY

CREATED ON: 01/18/2018	**SCHEDULED REVISION DATE:**	
DATE OF CHANGE:	**POLICY RESPONSIBILITY:**	**SUMMARY OF CHANGE:**
08/2018	KAREN SHELL	ADDED REQUIREMENT THAT THE CLIENT APPLIED TO CARE CREDIT OR THEIR OWN CREDIT CARD
07/2019	KAREN SHELL	REPLACED REQUIREMENT TO EMAIL THE APPLICATION TO EMAILING THE WORK ORDER NUMBER ONLY
01/2020	KAREN SHELL	ADDED CLARIFICATION THAT NON-COVERED OR DENIED ITEMS DO NOT QUALIFY FOR WAIVER OR DISCOUNT; ADDED DIRECTOR'S DESIGNEE AS AUTHORIZED TO REVIEW APPLICATIONS
08/2020	KAREN SHELL	ADDED CLARIFICATION ON POST-DELIVERY APPLICATIONS; CLARIFIED AMOUNT BASIS