	<b>Regulatory Compliance Policy</b>	<b>No. 4.2</b>
	<b>Subject:</b>  <b>Waivers of Co-Payments and Deductibles</b>  (Previously Entitled Administrative Write-Offs/Policy 2.7 of Administrative Policies and Procedures)	<b>Page: 1 of 7</b>
		<b>Original Date: 10/01/96</b>
		<b>Revised Date: 07/03/01</b>
		<b>Approved: David L. Dennis</b>

## 4.2 WAIVERS OF CO-PAYMENTS AND DEDUCTIBLES

### 4.2.1 POLICY


Tenet policy is that the portion of the patient bill that is the direct responsibility of the patient can be reduced or waived only under certain limited circumstances. This policy shall apply to all Tenet owned and affiliated provider entities including, but not limited to, acute care facilities, nursing facilities, rehabilitation facilities, home health agencies, Tenet Physician Services and other affiliated physicians. PLEASE NOTE THAT ALL WAIVERS MUST RECEIVE THE PRIOR APPROVAL OF REGIONAL COUNSEL.

### 4.2.2 PROCEDURES


#### 4.2.2.1 Patients Other Than Medicare, Medicaid and CHAMPUS

As a general rule, co-payments and deductibles can be waived for private pay patients (i.e., those with no primary or secondary governmental coverage) under the following circumstances:

- A. Waivers may be granted to the following classes of non-governmental funded patients:
- For physicians on the active staff at Tenet facilities/hospitals (however, waivers shall not be granted if a professional courtesy discount has already been given with respect to the items or services or if the physician has primary or secondary coverage under a governmental program); or
  - To the immediate family members (spouse, parents and children only) of physicians on the active staff at Tenet facilities/hospitals, (however, waivers will not be granted if a professional courtesy discount has already been given with respect to the items or services or if the family member has primary or secondary coverage under a governmental program); or
  - A determination has been made by Tenet personnel and documented that requiring payment would constitute a financial hardship for the patient; or

	<b>Regulatory Compliance Policy</b>	<b>No. 4.2</b>
	<b>Subject:</b>  <b>Waivers of Co-Payments and Deductibles</b>  (Previously Entitled Administrative Write-Offs/Policy 2.7 of Administrative Policies and Procedures)	<b>Page: 2 of 7</b>
		<b>Original Date: 10/01/96</b>
		<b>Revised Date: 07/03/01</b>
		<b>Approved: David L. Dennis</b>

- To a patient to allow a Tenet facility which does not have a managed care contract with a payor to attract patients of that payor by charging copayments and deductibles to the patients covered by the payor on the same basis as would apply if Tenet had a contract with the payor; or
  - As part of a prompt payment program pursuant to which co-payments and deductibles are appropriately reduced to reflect the time value of money and risk of non-collection if the patient pays at the time of service or within a time frame established by Tenet; or
  - To other classes of non-governmental funded patients as selected by the provider.
- B. Waivers resulting from each of the above types of program shall be disclosed to the patient and third party payor, with the form of disclosure being approved by Regional Counsel. It should be borne in mind that such waivers and disclosures may, depending upon the circumstances, result in the third party payor reducing or eliminating its payment for the service.
- C. Notwithstanding the foregoing, waivers based upon financial hardship need not be disclosed if such waiver is not offered at the time of service, but instead is offered in response to a request made by the patient after the third-party payor has adjudicated the claim.
- D. Regional Counsel must approve all waivers in writing as being in compliance with federal and state law (price, discrimination, disclosure requirements, form of disclosure, inducements, etc.). Regional Counsel will also confirm that the waiver is permitted under Tenet’s obligations under applicable payor contracts, which may expressly require the collection of copayments and deductibles.
- E. In no event shall Tenet represent to an insurer that it has billed or collected co-payments or deductibles if it has not in fact done so.
- F. Where a patient’s private coverage is secondary to Medicare, managed care contracts which contain coordination of benefits provisions which provide that Tenet will accept an agreed upon rate from the third-party payor or from the Medicare program


	<b>Regulatory Compliance Policy</b>	<b>No. 4.2</b>
	<b>Subject:</b>  <b>Waivers of Co-Payments and Deductibles</b>  (Previously Entitled Administrative Write- Offs/Policy 2.7 of Administrative Policies and Procedures)	<b>Page: 3 of 7</b>
		<b>Original Date: 10/01/96</b>
		<b>Revised Date: 07/03/01</b>
		<b>Approved: David L. Dennis</b>

as payment in full must be analyzed under Tenet’s policies at 4.2.2.2 below governing Medicare patients.

- G. Where charges are eliminated or reduced as the result of quality of care issues, the adjustment shall be made to the total charge, not just the patient’s co-payment or deductible part of the charge, so as to also benefit the applicable payor, and not just the patient.
- H. Other special circumstances may warrant a waiver, subject to the written approval of Regional Counsel. Questions on which other cases qualify should be referred to the Government Programs Department.
- I. See Administrative P&P 2.6, "Facility/Hospital Discounts and Service Agreements," for Tenet's policy on discounts for Tenet employees.


4.2.2.2 Medicare and Medicaid Patients

- A. Waivers of deductibles and co-payments for Medicare or Medicaid patients generally are not permitted unless the patient's inability to pay has been documented in accord with section 4.2.2.2.1 or section 4.2.2.2.2 below. The only exceptions to this are explained at subsections B and C immediately below.
- B. Under certain conditions, waivers of deductibles and co-payments for Medicare patients for inpatient hospital services that are reimbursed under the prospective payment system are permitted. These waivers must meet each of the following criteria:
  - The waiver should clearly indicate what is being waived (e.g., deductibles and co-payments).
  - The waiver cannot provide for the waiving of any other charges, for example personal comfort items such as private room, telephone, etc. which are provided to the patient, but which are not covered by the Medicare program. These amounts must be billed to the patient, and cannot be written off by the hospital. However, certain items, such as call back and standby fees, STAT charges, and

	<b>Regulatory Compliance Policy</b>	<b>No. 4.2</b>
	<b>Subject:</b>  <b>Waivers of Co-Payments and Deductibles</b>  (Previously Entitled Administrative Write-Offs/Policy 2.7 of Administrative Policies and Procedures)	<b>Page: 4 of 7</b>
		<b>Original Date: 10/01/96</b>
		<b>Revised Date: 07/03/01</b>
		<b>Approved: David L. Dennis</b>


use of portable equipment are covered by Medicare, but are not separately billable to Medicare. These items are not to be billed to patients, and are written off to the facility's covered non-billable account.

- The availability of the waiver cannot be limited based upon type of admission (i.e., cataracts or other special diagnosis), length of stay, or DRG for which the patient is treated. Any waiver program limited to a specific type or types of diagnosis is prohibited.
- The waiver cannot apply to the deductible and co-payments for Part B professional services, regardless of where the service is provided.
- Waivers for Medicare patients are not permitted for any non-hospital service or for any hospital services provided in the outpatient area, in a unit of an acute care facility/hospital (i.e., psychiatric, rehabilitation or skilled nursing unit) which is not subject to the Medicare prospective payment system, or in a free standing facility/hospital excluded from the Medicare prospective payment system and paid on a cost basis.
- Under no circumstances may the amounts waived be claimed as bad debt for Medicare reimbursement purposes. In addition, the burden of the waivers cannot otherwise be shifted onto Medicare, a state health care program, or any other private or public payor.
- The waiver cannot be offered pursuant to an agreement with a third party payor (e.g., Blue Cross plans, HMOs or private payors), for example, where the contract specifically indicates there will be a waiver of the beneficiary's co-payments and deductibles. The only exception to this requirement is if the contract is a Medicare supplemental policy issued under the terms of Section 1882(t)(1) of the Social Security Act, i.e., with a Medicare SELECT insurer.
- The waiver program has been approved in writing by Regional Counsel as satisfying any state law requirements.

	<b>Regulatory Compliance Policy</b>	<b>No. 4.2</b>
	<b>Subject:</b>  <b>Waivers of Co-Payments and Deductibles</b>  (Previously Entitled Administrative Write-Offs/Policy 2.7 of Administrative Policies and Procedures)	<b>Page: 5 of 7</b>
		<b>Original Date: 10/01/96</b>
		<b>Revised Date: 07/03/01</b>
		<b>Approved: David L. Dennis</b>

When all of the above standards are met, the hospital may elect to waive the deductibles and coinsurance for Medicare beneficiaries who are otherwise liable for these amounts.

- C. Medicare coinsurance can be waived as an incentive for patients to obtain preventive care services specifically described in the current U.S. Preventive Services Task Force’s Guide to Clinical Preventive Services.
- D. There may be special circumstances in some states where the above criteria do not apply. If you feel that your state is a "special case" where, for example, Medicare rules do not apply, such as in a waiver state, document the case and consult with Regional Counsel for guidance.
- E. Contracts with payors, other than Medicare SELECT insurers, which contain coordination of benefits provisions which provide that Tenet will accept an agreed upon rate from the third-party payor or from the Medicare program as payment in full are not permitted when the effect of such coordination of benefits provision is that the Medicare patient (or his or her insurer) would not pay applicable co-payments or deductibles. The applicable Medicare co-payments and deductible must be collected under these circumstances. Such provisions can be honored in contracts with Medicare SELECT insurers, but only to the extent that the requirements in 4.2.2.2.B above are satisfied.
- F. Waivers shall not be granted with respect to co-payment, deductible or "share of cost" requirements imposed upon patients by state Medicaid programs except as approved by Regional Counsel.
- G. Where charges are eliminated or reduced as the result of quality of care issues, the adjustment shall be made to the total charge, not just the patient’s co-payment or deductible part of the charge, so as to also benefit the applicable payor, and not just the patient.


	<b>Regulatory Compliance Policy</b>	<b>No. 4.2</b>
	<b>Subject:</b>  <b>Waivers of Co-Payments and Deductibles</b>  (Previously Entitled Administrative Write- Offs/Policy 2.7 of Administrative Policies and Procedures)	<b>Page: 6 of 7</b>
		<b>Original Date: 10/01/96</b>
		<b>Revised Date: 07/03/01</b>
		<b>Approved: David L. Dennis</b>

#### 4.2.2.2.1

#### Waivers For Indigent Medicare Hospital Patients

Medicare regulations state that if a facility/hospital can establish, prior to admission or shortly before discharge, that a patient is financially or medically indigent, the normal collection effort need not be made. The amount due can be forgiven to the patient and may be written off and claimed as a Medicare bad debt on the Medicare cost report. Under such situations, the patient's responsibility for co-payments and deductibles is waived and no further collection effort is made. The conditions under which a patient may be determined to be indigent where the amount will be claimed as bad debt require more than a mere declaration of hardship by the patient, or a cursory review by the provider staff. The steps to determine indigence are:

- The waiver shall be initiated pursuant to a specific request by the patient, and shall not be offered by the hospital as part of a general waiver program.
- The determination must be made by the provider and not the patient (i.e., a patient's signed declaration of his inability to pay his bills cannot be considered proof of indigency).
- All resources, including but not limited to the patient's assets (convertible to cash and unnecessary for daily living), liabilities, income and expenses must be considered. To do this, the provider must review items such as tax returns, income statements, W-2s and related documents and shall take into account any extenuating circumstances that would affect the determination of the patient's indigence.
- A determination must be made that the patient has no other outside resources (welfare agencies, Medigap insurance, or a guardian) who might be legally responsible for the medical bills.
- The actions taken to support the conclusion of indigence must be documented in the patient's file. Such documentation should include the method by which indigence was determined and all backup information necessary to substantiate the determination.

	<b>Regulatory Compliance Policy</b>	<b>No. 4.2</b>
	<b>Subject:</b>  <b>Waivers of Co-Payments and Deductibles</b>  (Previously Entitled Administrative Write-Offs/Policy 2.7 of Administrative Policies and Procedures)	<b>Page: 7 of 7</b>
		<b>Original Date: 10/01/96</b>
		<b>Revised Date: 07/03/01</b>
		<b>Approved: David L. Dennis</b>

Additional details on the accounting procedures to be used for the waivers of deductibles and co-payments for indigent patients have been distributed by the Tenet Government Programs Department in the past. This will be continued as the applicable rules are clarified. If questions occur regarding this matter, contact the Government Programs Department for guidance.

#### 4.2.2.2.2

#### Waivers For Indigent Non-Hospital Patients

The standards for determining medical indigency are less rigorous when the forgiven co-payments and deductibles will not be claimed as bad debt on a cost report. Providers not reimbursed pursuant to cost reports may forgive co-payments and deductibles based upon medical indigency under the following circumstances:

- The waiver has been initiated pursuant to a specific request by the patient, and is not offered by the provider as part of a general waiver program.
- The provider has determined in good faith that the patient is in financial need.

#### 4.2.2.3

#### CHAMPUS Patients

It is expressly prohibited by CHAMPUS regulations to waive the beneficiary's cost share. There are exceptions to this policy where the facility/hospital has entered into a specific agreement with a CHAMPUS demonstration program, for example CRI, CPA or CAMPO. Under these limited circumstances, the facility/hospital may be allowed to waive all or part of the beneficiary share of costs. Approval must be obtained from Regional Counsel prior to entering into such an agreement.

These foregoing policies and procedures are based on current interpretations of the applicable statutes and regulations and may change as clarification of the applicable rules is obtained. If there are any questions regarding these policies and procedures, contact Tenet Government Programs Department or your regional counsel in the Law Department.