Patient Discount and Financial Assistance Policy

Title:	Patient Discount and Financial Assistance Policy
Department:	Patient Billing Solutions
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Contact Person:	Director, Patient Billing Solutions

KEYWORDS:

FAP

PURPOSE:

The Patient Discount and Financial Assistance Policy outlines all circumstances under which patients are routinely provided discounts on bills for the services provided at Partners HealthCare facilities. This includes discounts based on the patient's insurance status, without regard to their financial status, and discounts based on the patient's financial status typically determined by verifying the patient's income and/or participation with a government sponsored health plan.

Partners HealthCare System affiliated entities recognize that some patients have limited means and may not have access to insurance coverage for all services. This policy has been developed to assist uninsured patients and underinsured patients with limited financial resources.

DEFINITIONS:

Uninsured Patient: A patient that does not have any health insurance in effect for a specific date of service or where their coverage in not effective for a specific service due to network limitations, insurance benefit exhaust or other non-covered services.
Medically Necessary Services: Services that are reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity. Medically Necessary Services include inpatient and outpatient services as authorized under Title XIX of the Social Security Act.

Emergent Services: Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity

including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e) (1) (B) of the Social Security Act, 42 U.S.C. § 1295dd(e)(1)(B). A medical screening examination and treatment for emergency medical conditions or any other such service rendered to the extent required pursuant to **EMTALA** (42 USC 1395(dd) qualifies as Emergency Care.
Emergent services also include:

- Services determined to be an emergency by a licensed medical professional;
- Inpatient medical care which is associated with the outpatient emergency care; and,
- Inpatient transfers from another acute care hospital to a Partners (PHS) hospital for the provision of inpatient care that is not otherwise available.

Urgent Services: Medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health.

Elective Services: Medically necessary services that do not meet the definition of Emergent or Urgent Services. The patient typically, but not exclusively, schedules these services in advance.

Other Services: Services where medical necessity has not been demonstrated to the reviewing clinician or where the patient's qualifications for the service may not meet the general insurance plan definitions for meeting key medical necessity criteria for the service. Services also include services where many insurance plans do not consider them to be Medically Necessary including, but not limited to: Cosmetic Surgery, In-Vitro Fertilization (IVF) or other Advanced Reproductive Therapy (ART), Gastric Bypass Services absent of a payer's determination of medical necessity, and Patient Convenience Items such as charges related to overnight services above and beyond those needed for medical care or patient overnight services (inpatient or partial hospitalization) where there isn't a clearly demonstrated medical necessity.

Medicare Bad Debt: The expense that CMS/Medicare allows hospitals to claim for most unpaid Medicare co-insurance and deductibles, provided the balance is completely processed per the established self-pay billing cycle or a determination is made that the patient is indigent for the purposes of the balance. The determination of indigence must be based on the patient's income level and a review of their available which typically excludes their vehicles and primary residence and a minimum bank/checking account.
Post Acute Care: Medically necessary services provided at a Hospital that is classified as post-acute care, including rehabilitation services.

Behavioral Health Services: Medically necessary services that focus on the patient's psychological and mental health, and may be provided in a number of care delivery settings.

Patient Discount and Financial Assistance Policy

Patient Billing Solutions (PBS): The department at Partners HealthCare responsible for all self-pay revenue cycle processes including Customer Service, Collections, Bad Debt processing, patient credits/refunds and associated processes.

POLICY STATEMENT:

Partners HealthCare affiliated entities are tax-exempt entities, whose underlying mission is to provide services to all in need of medical care. Patients requiring urgent or emergent services shall not be denied those services based on their inability to pay. Partners Post-Acute Care and Behavioral Health hospitals will work with patients who have a demonstrated financial need to provide financial assistance to those patients seeking care in those settings. However, for Partners HealthCare System affiliated entities to continue to provide high quality services and support community needs, each entity has a responsibility to seek prompt payment for services where collection is allowed and not in conflict with Commonwealth of MA regulations or Federal regulations including EMTALA.

Scope: This policy applies to the following Partners HealthCare entities:

- Acute Care Hospitals
  - Massachusetts General Hospital (MGH)
  - Brigham and Women's Hospital (BWH)
  - North Shore Medical Center (NSMC)
  - Newton-Wellesley Hospital (NWH)
  - Brigham and Women's Faulkner Hospital (BWFH)
  - Martha's Vineyard Hospital (MVH)
  - Nantucket Cottage Hospital (NCH)
  - Cooley Dickinson Hospital (CDH)
- Behavioral Heath Hospitals
  - McLean Hospital (MCL)
- Post Acute Care Hospitals
  - Spaulding Rehabilitation Hospital Boston (SRH)
  - Spaulding Hospital for Continuing Medical Care Cambridge (SHC)
  - Spaulding Rehabilitation Hospital Cape Cod (SCC)
- Physicians Organizations
  - Massachusetts General Physicians Organization (MGPO)
  - Brigham and Women's Physicians Organization (BWPO)
  - North Shore Physicians Group (NSPG)
  - Newton Wellesley Ambulatory Services (NWAS)
- Home Care
  - Partners HealthCare at Home (PHH)

Note that physicians associated with these entities, but who bill "privately" are encouraged, but not required, to follow this policy. Details may be found on the Partners HealthCare Provider Affiliate List.

Patient Discount and Financial Assistance Policy

Types of Discounts:

Overview

This policy establishes a common patient discount policy for Partners hospitals, their associated physician groups and Partners HealthCare at Home. Partners entities may in some cases continue to apply existing discounts that go beyond this policy with the approval of the local entity CFO.

Uninsured Patient Discount Program

All Partners Acute Care Hospitals, Physicians Organizations and Partners HealthCare at Home entities provide Uninsured Patients a 25% discount from charges, provided that the patient balance is either paid fully or arrangements are made with Partners for a payment plan, within 60 days of the initial statement. Uninsured Patient Discounts for SRN and MCL are available on selected patient services at varying rates with the details outlined in Appendix I. This program is inclusive of patients at all income levels with no financial qualifications or application required, although a patient must be current on all outstanding balances to qualify. Discounts are contingent on full payment of the agreed amount. Payment plans must meet the criteria outlined in the in the Partners Hospital Credit & Collection Policy.

Exclusions from Patient Discount Program

- Services that are classified as "Other Services" are excluded from this discount.
- Services provided by physicians who bill "privately" rather than through one of the physician groups are excluded from this discount.
- This is intended for Uninsured Patients so balances post insurance processing are generally excluded from this discount, including: co-payments, co-insurance and insurance deductibles.
- Discounts under this policy do not apply to cosmetic surgery, infertility services, motor vehicle claims, third party liability claims, fixed fee services, tele-health, e-visits (virtual visits), other non-medically necessary services or services where other discounts have already been included in the charge.

Financial Assistance Discounts/Financial Assistance Policy

Financial Assistance determinations are generally made post service delivery based on the patient's financial status, the type of service provided, the patient's insurance status and the general classification of service provided. Emergent Services will always be rendered without a review of the patient's financial status up to the limits required by EMTALA. This policy addresses all Medically Necessary services. However, only some types of Medically Necessary Services will qualify for a Financial Assistance Discount.

- Emergency Services and Urgent Services will generally qualify for discounts.
- Other Services are always excluded from Financial Assistance Discounts.
- In most cases, Elective Services, Post-Acute Care Services and Behavioral Health Services (non-emergency) are excluded from a Financial Assistance Discount. Elective Services, Post-Acute Care Services and Behavioral Health Services are typically

screened for financial clearance prior to service delivery and may be deferred based on the patient's overall medical status after a review with the appropriate providers.

Financial Assistance Discounts: DETAILS:

Patient Responsibilities

Patients must meet their responsibilities to qualify for financial assistance. Failure to meet these responsibilities will result in the patient being disqualified for consideration for Financial Assistance. These include:

1. Obligation to obtain and maintain insurance coverage if affordable coverage is available to them either from a government sponsored insurance program Medicaid/Medicare), commercial insurance from their employer or from ConnectorCare or similar program offered under the Affordable Care Act or any successor/replacement plan that may follow. Patient may be asked to submit evidence of having applied for coverage.
2. Patient must fully disclose any Workers Compensation, Motor Vehicle or Third Party Liability coverage and cooperate with requests to have claims processed by that coverage.
3. Obligation to submit all requested documentation of income, assets and residency that is needed to enroll in state coverage or to verify their qualifications for any PHS financial assistance in a timely manner.
4. Obligation to keep Partners HealthCare System entities appraised of current demographic and insurance information.
5. Obligation to pay all balances in accordance with agreed to timeframe.

Exclusions from Financial Assistance Discounts

- Patients who came to a Partners facility from outside our primary service area for care that a reasonable person could have anticipated would be needed will typically not be considered for a Financial Assistance Discount. This includes presenting themselves as an Emergency when the underlying condition was known to the patient prior to their travel to a Partners facility to receive care. Examples for exclusion include obstetrical care and specialties where the patient is already aware of a condition that they would reasonably expect needed care including oncology care, cardiac services, specialty rehabilitation services and psychiatric services.
    - This does not exclude emergency services due to an accident or complications from a pre-existing condition when a reasonable person would not have anticipated that emergent care would be needed prior to traveling to our service area.
- Patients who have health insurance with a limited provider network that Partners does not participate with and present for a service that could been delivered another facility that participates with their health plan or where other financial support was available, will typically not qualify for a financial assistance discount.
- Balances after insurance, including deductibles, co-insurance and co-payments are generally excluded from discounts.

    - Balances from Exhausted Benefits denials may be considered for a discount if all other qualifications are met and there was no insurance contractual applied to the balance.
- Other Services are excluded, including but not limited to
    - Cosmetic Surgery
    - In-Vitro Fertilization (IVF)
    - Advanced Reproductive Therapy (ART)
    - Gastric Bypass Services absent of a payer's determination of medical necessity
    - Patient Convenience items inclusive of premium accommodations and overnight accommodations that are based on a patient request and typically not covered by a health insurance plan
    - Other non-medically necessary services that are billed according to a pre-determined self-pay fee schedule
    - McLean Hospital: All Residential All-Inlcusive programs including, but not limited to, The Pavilion, The Appleton Residence at McLean, The Gunderson Residence, The McLean Center at Fernside, The McLean Residence at the Brook, The McLean Residence at Lincoln, Borden Cottage and 3East.

Service Qualifications for Financial Assistance Discounts

- Medically Necessary Services that meet the definition of Emergent Services or Urgent Services will be considered for Financial Assistance, provided that patient does not have insurance coverage available for the services, including Motor Vehicle coverage and Workers Compensation.
- Services that will qualify for a Financial Assistance Discount under limited circumstances include:
    - Elective Services only when:
        - Patient is a resident in Partners' primary service area and has applied for all available government and non-government programs. This is typically demonstrated by their enrollment in MassHealth Limited and/or the Massachusetts Health Safety Net (HSN). This only applies to services at an Acute Care Facility when the services do not qualify for billing to the HSN.
        - Services at an Acute Care facility are directly proximate, within 60 days, to an Urgent/Emergent Service and are follow up care for the earlier service
    - Post-Acute Care Services and Behavioral Health Services only when:
        - Pre-screening of the services identifies that the specialized services are only available at the Partners facility
        - The facility accepts the patient for care with the understanding that the patient has limited/no resources to pay for the care. These patients are typically from the Partners primary service area and are enrolled with MassHealth Limited and/or HSN, demonstrating their limited financial resources.
        - Behavioral Health (McLean Hospital): An established Patient who incurs significant expenses for Medically Necessary Elective Care who becomes Uninsured during therapy will be considered for Financial Assistance either until they are able to reestablish their health insurance or until their

care can be transferred to an appropriate setting. The recommendation of the patient's provider regarding the clinical necessity is required in addition to the patient meeting the routine Financial Assistance process.

Financial/Income Qualifications for Financial Assistance Discounts

Patients with demonstrated financial need, either due to limited income or because their medical bills are an excessive portion of their income, will be considered for discounts. For residents of the United States, the most recently published Federal Income Poverty Guide (FPG) will be used as the primary determinant. For non-US residents, a combination of income and available assets will be used to determine the appropriate discount available. In all cases, the total income of the family will be used in this determination. Discounts based solely on income are generally limited to patients with family incomes less than or equal to 300% of the FPG.

Federal Poverty Income Guide – February 1, 2018

	150% FPG	250% FPG	300% FPG
Family Size = 1	$18,210	$30,350	$36,420
Family Size = 2	$24,690	$41,150	$49,380
Family Size = 3	$31,170	$51,950	$62,340
Family Size = 4	$37,650	$62,750	$75,300
Family Size = 5	$44,130	$73,550	$88,265

Patients with a family income of more than 300% but less than or equal to 600% of the FPG may still qualify if they can demonstrate that their annual medical expenses exceeded 30% of their income in the most recent 12-month period. For families with an income of more than 600%, the threshold is medical bills exceeding 40% of their income. Expenses must have occurred within the prior 12 months and are limited to those expenses that could potentially qualify as a medical expense per the US IRS. Patients wishing to be considered for discounts under this policy must provide requested documentation of income, residence and qualifying medical expenses in a timely manner.

Use of Assets in Financial Assistance Determinations

Asset information is only used in Financial Assistance determinations in a few limited cases. These include:

- Review of applications submitted by patients residing outside the U.S. (excluding Canada)
- Patients who would typically not be considered eligible, except for some unique circumstances that merit individual consideration. These are often patients who are considered 'under-insured' and have very high medical bills due to large deductibles and co-insurance.
- Patients covered by Medicare who are being reviewed to determine if they meet the Medicare criteria for definition of indigence. That requires both an income review and an asset review. The patient must have an income of less than 201% of the FPG and assets of less than $10,000 for the first family member with an additional $3,000 for each additional family member. Asset determinations will never include the primary residence

or the primary automobile. Application for financial assistance will be proof that the patient has an inability to use assets to pay their outstanding balances. Qualifying balances resulting from a Medicare co-insurance or deductible will be noted and appropriately reported.

Discount Methodology and Rates

Per IRS 501(r), hospitals must limit charges to patients and services qualified under our Financial Assistance Policy (FAP) to the Amounts Generally Billed (AGB) to Commercial carriers and Medicare. Partners determines the AGB by first dividing total payments by total charges for all Commercial and Medicare plans in aggregate for the prior fiscal year to determine the Payment on Account Factor (PAF) for the prior fiscal year. This is generally done in December when the most accurate data is available with discount rates being updated in January. The minimum FAP discount for the current fiscal year is the inverse of the prior year PAF. This will reduce the charges billed to qualifying patients to no more than the AGB for the prior year.

Example:

Total Payments from Medicare and Commercial Plans	$200,000,000
Total Charges from Medicare and Commercial Plans	$500,000,000
PAF	40%
Net Minimum FAP Discount	60%

Current Financial Assistance Discount Rates

Family Income as % of FPG	***Discount for Acute Care Hospitals and Physicians Organizations***	***Discount for Spaulding Rehabilitation Network Hospitals and Partners Health Care at Home***	***Discount for McLean Hospital***
0 to 150%	100%	100%	100%
150.1 to 250%	85%	85%	80%
251 to 300%	70%	61%	60%

Family Income as % of FPG	***Medical Bills as a percent of income***	***Discount for Acute Care Hospitals and Physicians Organizations***	***Discount for Spaulding Rehabilitation Network Hospitals and Partners Health Care at Home***	***Discount for McLean Hospital***
301 – 600%	30%	70%	61%	60%
Over 600%	40%	70%	61%	60%

Application and Discount Process

Patients will be encouraged to apply for consideration of Financial Assistance in all cases where they meet the basic qualifications outlined in this policy. All applications will be reviewed

including cases where all the qualifications have not been satisfied. The application process can be initiated either directly with PBS Customer Service, PBS Collections or through contact with a Financial Counselor at any Partners hospital or health center. This policy and all application forms are also available at http://www.partners.org/for-patients/Patient-Financial-Assistance.aspx. This webpage may also be accessed from the Partners HealthCare home page from the drop-down menu under "For Patients."

Typically, only fully completed applications will be reviewed for consideration, with all applications being sent to PBS for final determination. All applications will be screened to determine if the patient has met his/her obligations, including the obligation to obtain any available insurance coverage. The patient's status will also be reviewed to determine if he/she might be eligible for any state or federal programs. Designated staff at PBS will review all applications, contact the applicant for follow up information and communicate outcomes to the applicant.

Discounts approved under this policy will be applied when a patient is deemed qualified. Interest free payment plans will be offered to patients per existing guidelines in the PHS Hospital Credit & Collection Policy. Those guidelines require a minimum monthly payment of $25 with a payment schedule of one year for balances less than $1,000 and two years for larger balances. All other collection practices, including those actions that may be taken for non-payment of balances are specified in the PHS Hospital Credit & Collection Policy. That policy can be found at http://www.partners.org/for-patients/Patient-Financial-Assistance.aspx.

Massachusetts Residents and the Health Safety Net (HSN)

Massachusetts residents with family incomes up to 150% generally qualify for Full Health Safety Net coverage and for Partial Health Safety Net coverage from 150% though 300% of the FPG. This coverage may be secondary to other insurance (Medicare, Medicaid or Commercial) and functions as a safety net for patients designated as Low Income per Massachusetts regulations. All Medically Necessary services are available to these patients at either no charge (Full HSN) or after they meet an annual deductible (Partial HSN) at all Partners Acute Care Hospitals, including hospital licensed health centers and designated hospital based physician practices, but excluding any copayment amounts that might be determined by a primary insurance coverage. There are three additional HSN programs (Confidential Services to Adults, Confidential Services to Minors and Medical Hardship) which are available to patients through the Partners PBS or through patient financial counselors.

HSN also has a Medical Hardship program that is available to MA residents at higher income levels. Patients should be encouraged to apply for this program when their out of pocket costs for medical care are a major portion of their income, generally more than 30% of their household income. Applications must be initiated by a Financial Counselor at an acute care hospital. Each application can include medical expenses incurred within the prior 12 months of filing an application with a limit of 3 applications in any year. All balances continue to be considered a valid self-pay balances until HSN approves the application. This does not convey general coverage in the HSN program. Patients will typically be informed of the program when they call Customer Services or a Financial Counselor with affordability concerns when they have large balances. Some limited proactive outreach is done by both Financial Counselors, for large inpatient balances, and Collections Representatives, for large guarantor balances. Patient Financial Counselors counsel all patients who either contact them or are referred to them

regarding the applicability of the program and work with the patient to complete the application and submit it to HSN.

Patients whose only coverage is MassHealth Limited and/or HSN are generally considered to be Uninsured since those programs do not function per standard insurance coverage rules. Balances due to Acute Care Hospitals as part of a Partial HSN deductible are eligible for the Uninsured Patient Discount.

Patients will also automatically qualify for applicable Financial Assistance discounts on Medically Necessary Services (Emergent, Urgent and Elective) at the MGPO, BWPO, NSPG and NWAS with the HSN status serving as determination of the patient's income qualification.

Financial assistance discounts for Post Acute Care Services and Behavioral Health Services may also be available with the determination to be made during the patient's financial pre-screening for these scheduled services.

Discount levels will be based on the family income level that can be inferred from their HSN status of full or partial.

Individual Consideration

Patients are encouraged to bring their unique financial situations to the attention of Patient Financial Services at any Partners hospital, or to Patient Billing Solutions. Partners affiliated entities may, in accordance with its Credit & Collections Policy, extend discounts beyond the other provisions in this policy on a case-by-case basis to recognize unique cases of financial hardship.

Publication and Dissemination of the Patient Discount and Financial Assistance Policy

The Partners Financial Assistance policy, application forms, and a plain language summary are available at http://www.partners.org/for-patients/Patient-Financial-Assistance.aspx. This webpage may also be accessed from the Partners HealthCare home page from the drop-down menu under "For Patients." The website includes various ways in which patients can apply for assistance, including a list of hospital and health center patient financial counseling locations; a central phone number; and an email address. The website also lets patients know that the application forms and assistance are free.

Information on the policy and how to apply is available at all applicable Partners entities with public communication accomplished in several ways:

- 11 x 17 notices posted in registration and other high traffic areas
- Plain language brochures that advertise the availability of Partners financial assistance options displayed in practices and Emergency Departments
- General information regarding availability of financial assistance is included on all patient statements
- Patient financial counseling resources available for any patient who requests assistance, has specific questions, or wants a paper application. Materials, including the policy, application form, and plain language summary, are available in English and other languages as required by regulation.

- Hospital community program staff are educated about the FAP, and are instructed to inform and notify their community constituents of the availability of financial assistance at Partners sites.

PROCEDURES:

OTHER APPLICABLE PARTNERS HEALTHCARE POLICIES:

REFERENCE:

(Optional) Relevant citations

ATTACHMENTS:

(Optional)

DEVELOPMENT AND CONSULTATION

(Mandatory) Enter key groups or leaders who were consulted and approved policy. This section helps to guide subsequent reviews of substantive policy revisions.

Reviewed by:	Original Review Date:	Revision Approval Dates:
Senior Finance Leaders, Director of Community Benefits, Director Government Payer, Patient Accounts Corporate Director Director of Public Payer Patient Access for Community Health	May 12, 2005	June 1, 2011 July 1, 2013, March 15, 2015
Director Government Payer, Director of Patient Billing Solutions, Vice President of Revenue Cycle Operations		December 1, 2013 April 4, 2014 September 1, 2014 March 25, 2015 February 4, 2016 February 1, 2018

Patient Discount and Financial Assistance Policy

Appendix I Behavioral Health and Post Acute Care Hospitals

Behavioral Health – McLean Hospital

All discounts follow the general guidelines regarding the timeliness of the payment or establishment of a payment plan within 60 days of billing. The patients accounts must all be current.

- Inpatient Psychiatric Admissions: 25% discount
- Outpatient Psychiatric Services (excluding programs with other discounts): 25% discount
- Night Fee associated with a Partial Hospitalization
    - Many payers do not provide coverage for the Night Fee which qualifies it for treatment under the Uninsured Patient Discount program. The lack of coverage excludes it from the Financial Assistance Policy discount guidelines.
    - Discount is available to all patients based on a sliding fee scale at the following Federal Poverty Guideline Income levels.
        - At or under 100% of the FPG - 90%
        - From 100.1% to 200% of the FPG - 75%
        - From 200.1% to 300% of the FPG - 50%
        - From 300.1% to 400% of the FPG - 25%
- Selected programs have established per diem rates for Uninsured Self Pay patients in lieu of discounts. The standard conditions for the timeliness of the payment apply.
    - Residential Programs
        - EATING DISORDER: $1,350.00
        - BELMONT ADOLESCENT and OCDI CHILD: $900.00
        - ORHCARD HOUSE and OCDI: $800.00
        - ADATP RES LEADER, HIL CTR WOMEN and NAUKEAG: $700.00
    - Partial Programs
        - EATING DISORDER: $1,150.00
        - BELMONT ADOLESCENT and OCDI CHILD: $700.00
        - OCDI: $600.00
        - ADATP, BHP ADULT, HIL CTR WOMEN, MSE ADULT, and NAUKEAG: $500.00
    - Designated procedures delivered on an Outpatient basis
        - NEUROPSYCHTEICS TMS Treatments
            - CPT 90867 (Initial) $805.00
            - CPT 90868 (Subsequent) $382.00
            - CPT 90869 (Subsequent Motor Threshold Re-determination) $593.00
        - CATS PROGRAM
            - CPT 96101 (Psychological Testing, per hour) 50%
            - CPT 96116 Neurobehavioral Status, per hour) 50%
            - CPT 96118 (Neuropsychological Test, per hour) 50%

Patient Discount and Financial Assistance Policy

Post Acute Care – Spaulding Rehabilitation Network

All discounts follow the general guidelines regarding the timeliness of the payment or establishment of a payment plan within 60 days of billing. The patients accounts must all be current.

Physical, Occupational, Speech Therapy or SRH Behavioral Health: fixed rates of

- $110/visit (regardless of time or modalities)
- $150/evaluation

Specialty Evaluations (ATEC, AAC, Lokomat) - $175/evaluation
Specialty Treatments (Lokomat, interpreter services, complex treatment, feeding treatment) - $125/visit
Physician Office Visit Technical Fee - $50/visit
Other office procedures or diagnostic testing – 50% discount