HARRIS HEALTH SYSTEM

ELIGIBILITY SERVICES DEPARTMENTAL GUIDELINES AND PROCEDURES

Effective Date: 08/01/2002

TITLE: **APPEAL OF FINANCIAL ASSISTANCE DETERMINATION**

PURPOSE: This policy defines the process for appealing a client's financial assistance determination.

GUIDELINES/PROCEDURES STATEMENT:

Clients who disagree with the findings of the financial assistance interview are entitled to appeal the Harris Health's decision. Clients are entitled to appeal any portion of the findings, inclusive of residency, income calculation, or any other information used to make the financial assistance determination.

ELABORATIONS:

I. DEFINITIONS:

A. **APPEAL:** The formal process by which an applicant for financial assistance from the Harris Health System tax fund may lodge a disagreement with the outcome of the financial determination process.

II. GENERAL GUIDELINES:

A. Each client, whether approved or denied for financial assistance, shall be given written notice of his right to appeal the department's decision. Such notice shall consist of the appropriate address for filing appeals, and notice of the availability of Harris Health System policies regarding eligibility for financial assistance. See Harris Health Form 283177, "Notification of Denial for Financial Assistance" and Harris Health Form 283183, "Notification of Financial Assistance Classification and Right to Request Appeal."

B. Clients who disagree with the financial assistance determination while they are in an Eligibility Center should be encouraged to speak with the onsite Eligibility Services Manager.

C. Managers should discuss the situation with the client, and should call Eligibility Services Administration for assistance or clarification if necessary. If the Manager is unable to resolve the situation to the client's satisfaction, the client should be notified that he may appeal the department's decision.

D. Requests for appeals may be submitted via Harris Health Form 283177, "Notification of Denial for Financial Assistance" or Harris Health Form 283183, "Notification of Financial Assistance Classification and Right to Request Appeal." These forms are provided to the client at the conclusion of the eligibility determination interview or review.

E. The client should complete the appeals request within sixty-five (65) days of the date the financial assistance determination was made and send it to the Appeals Committee, in care of Eligibility Services Administration. Appeals will be accepted by mail, or in-person delivery. The client may attach any documentation relevant to the eligibility process. The client will be given an opportunity to present his case to the committee in person.

F. Written records of all appeals documents shall be scanned into the Eligibility software system. See Harris Health System Eligibility Services Departmental Guidelines and Procedures 1.08, "Records Retention and Destruction."

III. RECEIPT AND REVIEW OF APPEALS:

A. Appeals will be date-stamped and logged into the Eligibility software system upon receipt. Harris Health Form 283181, "Receipt of Appeal" shall be mailed to the client within ten (10) business days of the receipt of the appeal.

B. Appeal Representative will review each incoming complaint to determine the accuracy of the financial assistance determination.

1. Harris Health Form 283179, "Additional Documents Needed For Your Appeal" will be sent to client if additional information is needed.

2. Harris Health Form 283180, "Notice of Change for Your Appeal" will be sent to the client if an error was made during the eligibility process and the financial classification needs to be revised appropriately.

3. Harris Health Form 283173, "Response to Your Request For Appeal" will be sent to the client if it does not qualify as an appeal, client just reports a status change such as income, marital status, address, health care coverage, etc.

4. Harris Health Form 283178, "Notice of Denial For Your Appeal" will be sent to the client if the initial review by the Appeals Representative determined that an appropriate denial was issued, the case will be ineligible to be heard by the Appeals Committee.

5. Harris Health Form 283184, "Notice of Past Appeal Deadline" will be sent to the client if the request of appeal received has passed the appeal deadline.

C. Appeals unresolved by the initial review shall be forwarded to the Committee for review at the next regularly scheduled meeting. The Appeal Representative will provide the client Harris Health Form 283188, "Notice of Hearing" to notice the appeal has been scheduled for hearing with the time, date, and place of the hearing. The notice shall encourage the client to provide evidence to the Appeals Committee prior to the hearing.

D. The department shall provide the client or representative an opportunity to review the documentation used by Harris Health System to support the financial assistance determination by providing a copy of that documentation and Harris Health Form 283186, "Certified Package for Hearing" to the client or representative at least seven (7) days prior to the hearing. Documents may be hand-delivered or mailed to clients with addresses within Harris County.

E. The department shall resolve all appeals within sixty (60) days of the date the appeal was received. This timeframe may be extended by thirty (30) days in extraordinary circumstances.

IV. COMMITTEE MEMBERSHIP:

A. The Committee will be comprised of the following members:

1. Appeals Representative of Eligibility Services Department (non-voting member);
2. Executive Administrator;
3. Director-level representative from Patient Business Services;

4. Director-level representative from Lyndon B. Johnson General Hospital (LBJ) and Ben Taub General Hospital (BT) appointed by the facility's administrator;
5. Director-level representative from the Community Health Program;
6. Administrative Director of Social Services; and
7. Representative from County Attorney's Office (only when a client is represented by an attorney).

B. Committee members are appointed for a term of two years. The committee members shall elect a chairperson who shall conduct all hearings. A quorum of four voting members must be present for appeals hearings.

V. COMMITTEE HEARING:

A. The Committee will meet once a month to review appeals. The client has the option to present his/her case to the committee in person with any additional information relevant to the financial assistance determination process. The client may choose to have a representative represent him/her at the hearing. Clients shall be allowed to ask questions of any witness. An interpreter will be provided if the patient's primary language is not English.

B. Clients are not required to attend the hearing in person. No appeal shall be denied due to the client's failure to attend the hearing. If the client chooses not to attend the hearing, or arrives late, the committee will proceed based on the evidence submitted prior to the hearing.

C. The Appeals Representative shall present the Harris Health's position of the case with relevant policy support, the documentation provided by the client at the time of the interview, and any additional information relevant to the client's appeal.

D. Committee members will review the evidence, ask questions of the client or other witnesses, and will deliberate to determine whether eligibility policy was followed. Committee members may not authorize changes to written policy.

E. The Committee is bound by Federal and state laws and regulations and by Harris Health System's published policy and procedures. No other rule, policy, or procedure may be used by the Committee during deliberation.

F. Committee members may not consider in its deliberations or decision, any evidence not produced in the appeal hearing, including any report of formal or informal investigation by any Harris Health employee or agent not offered as evidence during the hearing.

G. Neither the Appeals Representative of Eligibility Services Department, nor any member of the Harris County Attorney's office may take part in, or be present during, the deliberations or voting of the committee.

H. Harris Health Form 283187, "Notice of Eligibility Appeals Committee Final Outcome" includes the Committee's decision will be provided to the client within fourteen (14) days of that decision, but no longer than sixty (60) days from the date the appeal was received (ninety (90) days when the department has requested an extension as described in item III. E. above). This form will advise clients of the right to further appeal to the County Court of Harris County, and will cite Texas Health and Safety Code section 281.071(e).

REFERENCES/BIBLIOGRAPHY:

Texas Health and Safety Code, Section 281.071(e).

Harris Health System Eligibility Services Departmental Guidelines and Procedures 1.08, "Records Retention and Destruction"

Forms

Harris Health Form 283181, "Receipt of Appeal"

Harris Health Form 283179, "Additional Documents Needed For Your Appeal"

Harris Health Form 283180, "Notice of Change for Your Appeal"

Harris Health Form 283173, "Response to Your Request for Appeal"

Harris Health Form 283178, "Notice of Denial for Your Appeal"

Harris Health Form 283184, "Notice of Past Appeal Deadline"

Harris Health Form 283188, "Notice of Hearing"

Harris Health Form 283186, "Certified Package for Hearing"

Harris Health Form 283187, "Notice of Eligibility Appeals Committee Final Outcome"

Harris Health Form 283177, "Notification of Denial for Financial Assistance"

Harris Health Form 283183, "Notification of Financial Assistance Classification and Right to Request Appeal."

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health System Eligibility Services Department

REVIEW/REVISION HISTORY:

Effective Date	Version # (If Applicable)	Review/ Revision Date (Indicate Reviewed or Revised)	Approved by:
08/01/02	1.0		Adm Dir. Eligibility & Regis Svcs
	2.0	10/12/2007	Adm Dir. Eligibility & Regis Svcs
	3.0	12/01/2010	Adm Dir. Eligibility & Regis Svcs
	4.0	09/01/2011	Adm Dir. Eligibility & Regis Svcs
	5.0	01/17/2013	Adm Dir. Eligibility Svcs Dept.

281.071. Payment and Support

(a) The administrator shall inquire into a patient's circumstances and the circumstances of the patient's relatives legally responsible for the patient's support if the patient is admitted to district facilities from the county in which the hospital is located. If the administrator finds that the patient or the patient's relatives are liable for the patient's care and treatment in whole or in part, the administrator shall issue an order directing the patient or the patient's relatives to pay to the district treasurer a specified amount each week in proportion to the financial ability of the patient or the patient's relatives to pay.

(b) A patient or the patient's relatives may not be required to pay an amount greater than the actual per capita cost of maintenance.

(c) An administrator may collect an amount owed under this section from the estate of a patient, or the relatives legally responsible for the patient's support, in the manner provided by law for the collection of expenses of the last illness of a deceased person.

(d) If the administrator finds that the patient and the patient's relatives are not able to pay in whole or in part, the district shall without charge supply the care and treatment to the patient.

(e) A county court of the county in which a patient's hospital is located shall hear and determine the ability of the patient or the patient's relatives to pay under this section if there is a dispute over this ability or if there is doubt in the mind of the administrator over this ability. The court shall hear witnesses and issue any order that may be proper.

(f) An appeal from an order of the county court must be made to a district court in the county in which the district is located.

Acts 1989, 71st Leg., ch. 678, § 1, eff. Sept. 1, 1989.