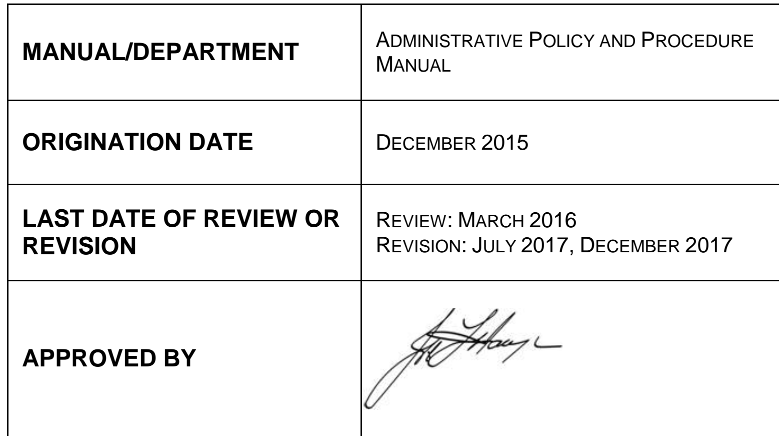
Children's Hospital Colorado



MANUAL/DEPARTMENT	ADMINISTRATIVE POLICY AND PROCEDURE MANUAL
ORIGINATION DATE	DECEMBER 2015
LAST DATE OF REVIEW OR REVISION	REVIEW: MARCH 2016 REVISION: JULY 2017, DECEMBER 2017
APPROVED BY	

TITLE: FINANCIAL ASSISTANCE POLICY (FAP) PUBLIC POLICY

PURPOSE

Children's Hospital Colorado (CHCO) is committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Consistent with our mission to improve the health of children through the provision of high-quality, coordinated programs of patient care, education, research and advocacy, CHCO strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. CHCO will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

This policy helps to:

1. Define how patients are determined to be eligible for charity funds and discounted care in accordance with CHCO's Non-Discrimination of Patients policy and IRS regulations.
2. Standardize the process to assess a patient/family's ability to pay for services and to collect appropriate reimbursement based on qualifications and the Federal/State poverty guidelines for CHCO.
3. Define the policy for billing and collecting money from patients/families that are paying for their medical care while making sure that CHCO has a reasonable way to collect payments owed.

SCOPE/PERSONNEL

All CHCO staff at all CHCO locations and CHCO Patients and Families

DEFINITIONS

Accounts Receivables (A/R)	Money owed by customers to Children's Hospital Colorado in exchange for care and services that have been delivered or used, but not yet paid.
Bad Debt	An account receivable based on services provided to a patient that is regarded as uncollectable, following reasonable collection efforts and aged at least120 days from the date the hospital provided the first post-discharge billing statement for the care, consistent with IRS section 501(r) requirements.
Children's Charity Care	A CHCO discount program for indigent patients who are not eligible for any other coverage (e.g., Medicaid, CHP+ or CICP, commercial insurance).
Colorado residence qualification	Proof of residency requires applicants provide a utility or phone bill, lease agreement or mortgage statement, communication from the child's school, identification cards (i.e.,—Driver's license, state issued ID), bank statement, or a letter of support from a family member or friend.
Extraordinary Collection Actions (ECA)	ECAs are actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that require a legal or judicial process (except certain liens or bankruptcy claims), involve selling an individual's debt to another party unless certain contractual terms are in place, or involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, ''credit agencies'').
Financial Assistance Policy (FAP)	The hospital policy that describes the: o Eligibility rules for financial help and whether such help includes free or discounted care; o Financial assistance and discounts available to qualified individuals; o Basis for calculating the amounts charged to patients; o Method for asking for financial assistance; and

	○ List of any providers delivering care in the hospital and which, if any, are covered by the facility's FAP and which are not.
Federal Poverty Level (FPL)	A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine eligibility for certain programs and benefits. Federal Poverty Guidelines are published annually by the Federal Government.
Foreign National	Non- US citizens who are residing in or visiting the US and are in need of medical services.
Guarantor	The person who is responsible for paying the patient's bill.
Guarantor Statement	A bill for care given. It is a summary of billing and payment information about patient accounts linked to one guarantor.
Income	Includes earnings, unemployment compensation, workers' compensation, Social Security, supplemental security income, public assistance, veterans payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Non-cash benefits (such as food stamps and housing subsidies) do not count. Family income is calculated before taxes and excludes unrealized capital gains or losses. It can include other unearned income which is countable gross cash received from sources other than employment.
Liquid Assets	Assets that can be converted into cash in a relatively short period of time, generally within 30 days. This includes, but is not limited to, checking accounts, saving accounts, trust accounts (if funds are available immediately), the cash value of life insurance, short-term Certificates of Deposit (CDs) and partnership earnings kept in reserve. Retirement accounts and Tax Sheltered Annuities are liquid resources, if the applicant can draw funds out of the account without a penalty.
Medical Emergency	An injury or illness that is acute and poses an immediate risk to a person's life or long term health.
Medical Necessity	A covered service will be deemed medically necessary if, in a manner consistent with accepted standards of medical practice, it is found to be an equally effective treatment among other less conservative or more costly options, and meets at least one of the following criteria: • The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability or secondary disability; • The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental, cognitive or developmental effects of an illness, injury or disability; • The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability; • The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living.
Non-covered charge	Incurred charges that are deemed not a covered benefit per the patient's/guarantor's insurer.
Self-Pay	Patient does not have, or chooses not to use, commercial insurance, government program coverage, or other financial assistance. At the time of billing, a 35% discount will be applied to all self-pay balances.

FINANCIAL ASSISTANCE POLICY

1. Medical emergency services are eligible to be considered for Financial Assistance to U.S. residents.
2. Charity Eligibility
   A. The applicant(s) income must be below 250% of federal poverty guidelines.
   B. Charity care funding for non-emergency care is available to U.S. residents:
      1) Age 14 and younger who are Colorado residents; or
      2) Age 15 years and older who are Colorado residents may be eligible but require administrative approval; and
      3) Undocumented Colorado residents (within age requirements).
   C. The applicant(s) must be ineligible for Medicaid, Child Health Plan+ (CHP+), Colorado Indigent Care Program (CICP), or other health insurance. However, if an individual has Emergency Medicaid for an inpatient life or limb threatening condition, the applicant may be eligible for Charity.
   D. Charity may act as a secondary payer if the patient has commercial coverage. The secondary coverage may provide for a reduction in the amount of co-payments, deductibles, and co-insurance. In addition, charity care may also be used in cases when insurance benefits have been exhausted and services are deemed medically necessary (i.e., PT/OT, EDU, Audiology, Speech and Learning services).

E. A complete application for charity care assistance is required prior to determining eligibility
   1) The information that may be required to determine charity care eligibility is listed in the application.
   2) If charity care will be used to cover past dates of service, the patient/family must indicate the request for assistance on the application.

F. Application Period
   1) The application must be completed within 365 days from the date that the first post-discharge billing statement for the care is provided. Any services prior to 365 days from the application date will not be eligible for charity care coverage.
   2) If an incomplete application is submitted within the application period, the individual will have 60 days to complete the application before ECAs will occur. If ECAs have already started, CHCO will stop ECAs during the 60 day period. At this time the individual will be informed about missing information and how to get assistance.
   3) If a complete application is received, ECAs will be suspended until a determination is made and, if the individual is found eligible, ECAs will be reversed, refunds made, and if amounts are still owed a statement will be provided showing how that amount was determined.

3. Expectations for patients eligible for charity care assistance. The applicant must:
   A. Notify CHCO if there is a change in financial and/or coverage status; failure to do so may result in termination from the program;
   B. Pay the charity co-payment(s) at the time of service; and
   C. Bring the Charity identification card to every visit.

4. Charity Care Ineligibility Criteria – Patients are not eligible for charity care when the following scenarios arise:
   A. CHCO determines or identifies that the patient/family provided false information.
   B. The patient is not a Colorado resident and/or foreign national and is receiving non-emergent care.
   C. The patient/family fails to comply with application requirements for other programs (e.g., Medicaid, CICP, exchange plans, etc.).
   D. The patient/family fails to provide the required information within one (1) year of the date of service.
   E. Certain specialty services and specialties are normally not covered, unless deemed medically necessary:
      1) Transplants, which require a clinical assessment for non-emergency care to ensure the patient can adhere to the post-transplant medical requirements.
      2) Procedures denied by a medical insurance provider as “Non-Covered” benefits. Including:
         a. Services incurred prior to obtaining authorization from the patient’s insurance;
         b. Experimental procedures;
         c. Services denied by payers for non-compliance by the member (e.g., coordination of benefits not submitted).
      3) Services under research.

5. The Financial Counseling Department is the final authority for determining that the hospital facility has made reasonable efforts to determine whether an individual is FAP-eligible.

Note: CHCO can make changes to the Financial Assistance Program at any time without notice.

BILLING AND COLLECTIONS POLICY

1. CHCO will seek payment on accounts with balances in self-pay (i.e., patient liability). CHCO does not take part in extraordinary collection actions (ECA) before making reasonable efforts to decide whether financial assistance is available and/or collection efforts have been pursued. Any itemized statement requested by a guarantor will be given within ten (10) days of such request, in compliance with Colorado Revised Statute § 25-3-112.

2. CHCO will make reasonable efforts to notify patients and families about the FAP through the following methods:
   A. Orally notify individuals about the FAP and how to obtain assistance with the application process.
   B. CHCO will refrain from initiating ECAs for at least 120 days from the date the hospital facility provides the first post-discharge billing statement for the care.
   C. CHCO will send at least three (3) monthly billing notices, every thirty (30) days, to the guarantor of an account informing of a balance due.
      1) First Notice informs the guarantor that there is an unpaid balance due on an account;

2) Second Notice reminds the guarantor of continued unpaid balance;
3) Final Notice of the past due account notifies the guarantor that he/she has thirty (30) days to resolve the debt, or ECAs may be taken on the debt and will specify the ECAs that CHCO intends to take and include a copy of the copy of plain language summary.
   Note: The account can either be paid in full, set up on a payment plan, referred to financial counseling, or more insurance information obtained during this timeline. A plain language notice of CHCO's FAP is provided in both English and Spanish on every billing statement.

D. After three (3) billing notices have been sent and no payment is received within sixty (60) days of the Final Notice, the account may be turned to Bad Debt and ECAs may be taken.
   1) Accounts qualify for Bad Debt when patient balances (i.e., self-pay) have not been paid and the hospital has made reasonable efforts, that include but are not limited to phone calls, statements or letters, to decide whether the individual is eligible for Financial Assistance.
   2) The bad debt agency will report to the credit bureau sixty (60) days after an account is placed with such bad debt agency if no action is taken by the guarantor to resolve the balance either by making a payment or by submitting additional dispute information.
   3) If all other options to collect payment have been taken and an account in bad debt has aged more than sixty (60) days without contact from the guarantor or the guarantor refuses to resolve the balance, legal action may be taken.

E. Initiation of a Financial Assistance Application
   1) The application period for financial assistance will end no earlier than 240 days from the first post-visit bill.

F. All parties engaged in collection actions for CHCO will follow to this policy.

GENERAL INFORMATION

1. In order to preserve CHCO's ability to serve the pediatric health care needs of the community, uninsured or underinsured persons seeking scheduled, medically necessary services will be financially evaluated prior to physician evaluation. If a patient presents for an emergent or urgent condition, determining financial assistance needs will occur after stabilization and treatment. See EMTALA (Emergency Medical Treatment and Labor Act) policy.
2. CICP and the CHCO Charity Program are not insurance programs, but rather discount programs for those who are uninsured, or under-insured and have demonstrated financial need.
3. CHCO will not participate in nor support any activities (including media access) related to fundraising efforts intended to pay for a specific patient's care.
4. CHCO's Charity Program is not responsible for housing, food, transportation, immigration status, or continuity of care.
5. CHCO is available to help identify community based resources, facilitate services, and provide appropriate referral assistance. A Financial Counselor may be contacted at 720-777-7001.
6. CHCO is not obligated to provide Charity Care for non-emergency medical services.
7. CHCO acts in accordance with Colorado Revised Statute § 25-3-112 and 26 CFR 1.501(r)-0 through 26 CFR 1.501(r)-7.
8. Copies are available in multiple languages, including English and Spanish.

AMOUNTS GENERALLY BILLED (AGB)

CHCO limits the amount charged for care it provides to any individual who is eligible for assistance under its Financial Assistance Policy (FAP). The amounts billed for emergency and medically necessary medical services to patients eligible for Financial Assistance are calculated based on the look-back method and will not be more than the AGB to individuals with insurance covering such care. CHCO is using the "look-back" method based on actual past claims paid to the hospital facility by Medicare fee-for-service together with all private health insurers paying claims to the hospital facility (including, in each case, any associated portions of these claims paid by Medicare beneficiaries or insured individuals). CHCO calculates an AGB percentage for each facility and uses the lowest percentage for all facilities, which is 58.38%. The ABG percentage will be reviewed and updated by the 120th day after the 12 month period the hospital facility used in calculating the AGB percentage, which is April every year for CHCO.

PROVIDER INFORMATION

1. Completed financial assessments will apply to the professional charges, providers covered under CHCO FAP include:

A. University of Colorado Medicine
B. Kay McDivitt, M.D.

2. The following professional charges will not be covered by CHCO FAP. These organizations may have their own financial assistance policies and inquiries should be made directly by the patient.
   A. TCH Radiology Professionals
   B. Radiology & Imaging Consultants, P.C. (RIC)
   C. University of Colorado Medicine Path Lab

ASSISTANCE AND METHODS FOR APPLYING

1. Applications and assistance in completing applications are available for free:
   A. Online (http://www.childrenscolorado.org/about/your-bill);
   B. At the Anschutz Medical Campus located at 13123 East 16th Avenue, Aurora, CO 80045 or the Briargate Urgent and Outpatient Specialty Care at 4125 Briargate Parkway, Colorado Springs, CO 80920; or
   C. By calling the Financial Counseling Department at 720-777-7001.
2. Completed applications cannot be mailed in, they must be submitted in person.

POLICY AND PLAIN LANGUAGE SUMMARY ACCESS

1. A copy of this policy and the plain language summary are available for free:
   A. Online (http://www.childrenscolorado.org/about/your-bill);
   B. At our Anschutz Medical Campus located at 13123 East 16th Avenue, Aurora, CO 80045 or our Briargate Urgent and Outpatient Specialty Care at 4125 Briargate Parkway, Colorado Springs, CO 80920; or
   C. Financial Counseling Department at 720-777-7001 or Patient Financial Services at 720-777-6422.
   D. Emailing pfs@childrenscolorado.org

ELIGIBILITY INFORMATION

1. Ineligibility for Medicaid, Child Health Plan+, Colorado Indigent Care Program, and other health insurance.
2. Household size and income, with consideration to liquid assets, below 250% of the Federal Poverty Level.
3. Submission of required information within 365 days from the date that the first post-discharge billing statement for the care is provided.

Federal Poverty Level (FPL) income guidelines chart are used to determine CHCO Charity Program Annual Maximum Income Guidelines. Information provided here is updated in April of each year.

Family Size	Annual Income
1	$29,700
2	$40,050
3	$50,400
4	$60,750
5	$71,100
6	$81,450
7	$91,800
8	$102,150

Charity Rating	Percent of Federal Poverty
N	40%
A	62%
B	81%
C	100%
D	117%
E	133%
F	159%
G	185%
H	200%
I	250%
Z*	40%

*Z ratings are for homeless clients.

RELATED DOCUMENTS/REFERENCE

1. 26 CFR 1.501(r)-0 through 26 CFR 1.501(r)-7
2. https://www.irs.gov/pub/irs-irbs/irb15-05.pdf

REVIEWED BY

Finance
Revenue Cycle
Administrative Policy and Procedure Committee
Executive Team

CHCO/CU MEDICINE CICP and Charity Copayment Schedule

Calendar Year 2017

Outpatient Clinic Visit (Primary and Preventative care, CHC, ADO MED, YM, CAMP)

	Charity			CICP		
Rating	CHCO	CU Med	Total	CHCO	CU MED	Total
0-40%=N	$7	$7	$14	$7	$0	$7
41-62%=A	$15	$15	$30	$15	$0	$15
63-81%=B	$15	$15	$30	$15	$0	$15
82-100%=C	$20	$20	$40	$20	$0	$20
101-117%=D	$20	$20	$40	$20	$0	$20
118-133%=E	$25	$25	$50	$25	$0	$25
134-159%=F	$25	$25	$50	$25	$0	$25
160-185%=G	$35	$35	$70	$35	$0	$35
186-200%=H	$35	$35	$70	$35	$0	$35
201-250%=I	$40	$40	$80	$40	$0	$40
0%-Z	$0	$0	$0	$0	$0	$0

Specialty Outpatient Clinic Visit (Distinctive med care Oncology, Ortho, CCBD, Cardio, etc.)

	Charity			CICP		
Rating	CHCO	CU MED	Total	CHCO	CU MED	Total
0-40%=N	$15	$15	$30	$15	$0	$15
41-62%=A	$25	$25	$50	$25	$0	$25
63-81%=B	$25	$25	$50	$25	$0	$25
82-100%=C	$30	$30	$60	$30	$0	$30
101-117%=D	$30	$30	$60	$30	$0	$30
118-133%=E	$35	$35	$70	$35	$0	$35
134-159%=F	$35	$35	$70	$35	$0	$35
160-185%=G	$45	$45	$90	$45	$0	$45
186-200%=H	$45	$45	$90	$45	$0	$45
201-250%=I	$50	$50	$100	$50	$0	$50
0%-Z	$0	$0	$0	$0	$0	$0

Ancillary Services (XR, PFT, Ultrasound, Intervent Radiology, Stress Test, Genetic Testing)

	Charity			CICP		
Rating	CHCO	CU MED	Total	CHCO	CU MED	Total
0-40%=N	$15	$0	$15	$15	$0	$15
41-62%=A	$25	$0	$25	$25	$0	$25
63-81%=B	$25	$0	$25	$25	$0	$25
82-100%=C	$30	$0	$30	$30	$0	$30
101-117%=D	$30	$0	$30	$30	$0	$30
118-133%=E	$35	$0	$35	$35	$0	$35
134-159%=F	$35	$0	$35	$35	$0	$35
160-185%=G	$45	$0	$45	$45	$0	$45
186-200%=H	$45	$0	$45	$45	$0	$45
201-250%=I	$50	$0	$50	$50	$0	$50
0%-Z	$0	$0	$0	$0	$0	$0

Inpatient Admission, Observation, Bedded Outpatient and Sleep Studies

	Charity			CICP		
Rating	CHCO	CU MED	Total	CHCO	CU MED	Total
0-40%=N	$15	$7	$22	$15	$7	$22
41-62%=A	$65	$35	$100	$65	$35	$100
63-81%=B	$105	$55	$160	$105	$55	$160
82-100%=C	$155	$80	$235	$155	$80	$235
101-117%=D	$220	$110	$330	$220	$110	$330
118-133%=E	$300	$150	$450	$300	$150	$450
134-159%=F	$390	$195	$585	$390	$195	$585
160-185%=G	$535	$270	$805	$535	$270	$805
186-200%=H	$600	$300	$900	$600	$300	$900
201-250%=I	$630	$315	$945	$630	$315	$945
0%-Z	$0	$0	$0	$0	$0	$0

Outpatient Surgery

	Charity			CICP		
Rating	CHCO	CU MED	Total	CHCO	CU MED	Total
0-40%=N	$15	$7	$22	$15	$7	$22
41-62%=A	$65	$35	$100	$65	$35	$100
63-81%=B	$105	$55	$160	$105	$55	$160
82-100%=C	$155	$80	$235	$155	$80	$235
101-117%=D	$220	$110	$330	$220	$110	$330
118-133%=E	$300	$150	$450	$300	$150	$450
134-159%=F	$390	$195	$585	$390	$195	$585
160-185%=G	$535	$270	$805	$535	$270	$805
186-200%=H	$600	$300	$900	$600	$300	$900
201-250%=I	$630	$315	$945	$630	$315	$945
0%-Z	$0	$0	$0	$0	$0	$0

Outpatient Services (CT, MRI, PET, EMG, Cath Lab, Nuc Med)

	Charity			CICP		
Rating	CHCO	CU MED	Total	CHCO	CU MED	Total
0-40%=N	$30	$22	$52	$30	$22	$52
41-62%=A	$90	$50	$140	$90	$50	$140
63-81%=B	$130	$80	$210	$130	$80	$210
82-100%=C	$185	$110	$295	$185	$110	$295
101-117%=D	$250	$140	$390	$250	$140	$390
118-133%=E	$335	$185	$520	$335	$185	$520
134-159%=F	$425	$230	$655	$425	$230	$655
160-185%=G	$580	$315	$895	$580	$315	$895
186-200%=H	$645	$345	$990	$645	$345	$990
201-250%=I	$680	$365	$1,045	$680	$365	$1,045
0%-Z	$0	$0	$0	$0	$0	$0

ED & Urgent Care

	Charity			CICP		
Rating	CHCO	CU MED	Total	CHCO	CU MED	Total
0-40%=N	$15	$7	$22	$15	$7	$22
41-62%=A	$25	$35	$60	$25	$35	$60
63-81%=B	$25	$55	$80	$25	$55	$80
82-100%=C	$30	$80	$110	$30	$80	$110
101-117%=D	$30	$110	$140	$30	$110	$140
118-133%=E	$35	$150	$185	$35	$150	$185
134-159%=F	$35	$195	$230	$35	$195	$230
160-185%=G	$45	$270	$315	$45	$270	$315
186-200%=H	$45	$300	$345	$45	$300	$345
201-250%=I	$50	$315	$365	$50	$315	$365
0%-Z	$0	$0	$0	$0	$0	$0

Prescription and Optical Shop

	Charity			CICP		
Rating	CHCO	CU MED	Total	CHCO	CU MED	Total
0-40%=N	$5	$0	$5	$5	$0	$5
41-62%=A	$10	$0	$10	$10	$0	$10
63-81%=B	$10	$0	$10	$10	$0	$10
82-100%=C	$15	$0	$15	$15	$0	$15
101-117%=D	$15	$0	$15	$15	$0	$15
118-133%=E	$20	$0	$20	$20	$0	$20
134-159%=F	$20	$0	$20	$20	$0	$20
160-185%=G	$30	$0	$30	$30	$0	$30
186-200%=H	$30	$0	$30	$30	$0	$30
201-250%=I	$35	$0	$35	$35	$0	$35
0%-Z	$0	$0	$0	$0	$0	$0

Outpatient Lab

	Charity			CICP		
Rating	CHCO	CU MED	Total	CHCO	CU MED	Total
0-40%=N	$5	$0	$5	$5	$0	$5
41-62%=A	$10	$0	$10	$10	$0	$10
63-81%=B	$10	$0	$10	$10	$0	$10
82-100%=C	$15	$0	$15	$15	$0	$15
101-117%=D	$15	$0	$15	$15	$0	$15
118-133%=E	$20	$0	$20	$20	$0	$20
134-159%=F	$20	$0	$20	$20	$0	$20
160-185%=G	$30	$0	$30	$30	$0	$30
186-200%=H	$30	$0	$30	$30	$0	$30
201-250%=I	$35	$0	$35	$35	$0	$35
0%-Z	$0	$0	$0	$0	$0	$0

The **Hospital Inpatient & Ambulatory Surgery** copayment is required for charges related to non-physician (facility) services incurred while receiving care in a hospital for a continuous stay of 24 hours or longer or Ambulatory Surgery for operative procedures received by a client who is admitted to and discharged form the hospital setting on the same day.

The **Inpatient and Emergency Room Physician** copayment is required for charges related to services provided directly by the physician in the hospital setting, including emergency room care.

The **Outpatient Clinic** copayment is required for charges related to non-physician (facility) **and** physician services received in the outpatient clinic setting. This includes charges for primary and preventive medical care. Does not include charges for outpatient services provided in a hospital (i.e., emergency room care, outpatient surgery, radiology).

The **Hospital Emergency Room** copayment is required for charges related to non-physician (facility) services incurred while receiving care in the hospital setting for a continuous stay of less than 24 hours, including in the Emergency Room.

The **Specialty Outpatient Clinic** copayment is required for charges related to non-physician (facility) **and** physician services received in the specialty outpatient clinic setting, but does not include charges for outpatient services provided in the hospital setting (i.e., emergency room physician, ambulatory surgery). Specialty outpatient charges include distinctive medical care (i.e, oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventative medical care.

The **Prescription** copayment is required for prescription drugs received at a qualified CICP health care provider's pharmacy.

The **Laboratory Services** copayment is required for charges related to laboratory tests received by the client that are not associated with an inpatient facility or hospital outpatient charge during the same period; radiology and imaging services in clinic setting.

Outpatient Services- ***Increased*** clients receiving a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET), Sleep Studies, Catheterization laboratory (cath Lab), or other Nuclear Medicine services in an Outpatient Setting are responsible for the copayment which is reflected in the chart.

Ancillary Services are services that are performed at CHCO outside of a specific Primary Care of Specialty Clinic, Inpatient, Outpatient, Ambulatory Surgery, ED or Urgent Care visits (e.g., X-Rays (flat films), ultrasounds, stress tests, pulmonary functiontion test, ECG, etc)