TORRANCE MEMORIAL A CEDARS-SINAI AFFILIATE	Department: ADMINISTRATION Policy/Procedure: **FINANCIAL ASSISTANCE POLICY** Full Charity Care and Discount Partial Charity Care Policies

PURPOSE

Torrance Memorial Medical Center (TMMC) is a non-profit organization which provides hospital services to the community of Torrance and the greater South Bay area of Southern California. TMMC is committed to meeting the health care needs of all patients in the community, including those who may be uninsured or underinsured. As part of fulfilling this commitment, TMMC provides medically necessary services, without cost or at a reduced cost, to patients who qualify in accordance with the requirements of this Financial Assistance Policy. This policy defines the TMMC Financial Assistance Program; its criteria, systems, and methods.

California acute care hospitals must comply with Health & Safety Code requirements as well as regulations under section 501(r) of the Affordable Care Act for written policies providing discounts and charity care to financially qualified patients. This policy is intended to meet such legal obligations and provides for both charity care and discounts to patients who financially qualify under the terms and conditions of the TMMC Financial Assistance Program.

The Finance Department has responsibility for general accounting policies and procedures. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at TMMC. This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of TMMC.

SCOPE

The Financial Assistance Policy will apply to all patients who receive medically necessary services[1] at TMMC. This policy pertains to financial assistance provided by TMMC. All requests for financial assistance from patients, patient families, physicians or hospital staff shall be addressed in accordance with this policy.

INTRODUCTION

TMMC strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services. TMMC is committed to providing access to financial assistance programs when patients are uninsured or underinsured and may need help in paying their hospital bill. These programs include government-sponsored coverage programs, Full Charity Care, and Discount Partial Charity Care as defined herein.

[1] Medically necessary services are defined as any hospital inpatient, outpatient, or emergency medical care that is not entirely elective for patient comfort and/or convenience.

The Financial Assistance Policy is applicable to all physicians that are contracted with TMMC and are required to participate in the application of this policy as a condition of their contractual relationship with TMMC (See Addendum B for a complete list of TMMC providers and those who participate in this Financial Assistance Policy).

Full Charity Care and Discount Partial Charity Care Defined

Full Charity Care is defined as any medically necessary inpatient or outpatient hospital service provided to a patient who is unable to pay for care and who has established qualification in accordance with requirements contained in the Financial Assistance Policy.

Discount Partial Charity Care is defined as any medically necessary inpatient or outpatient hospital service provided to a patient who is uninsured or underinsured and 1) desires assistance with paying their hospital bill; 2) has an income at or below 450% of the federal poverty level (FPL); and 3) who has established qualification in accordance with requirements contained in the Financial Assistance Policy.

Depending upon individual patient eligibility, financial assistance may be granted for Full Charity Care or Discount Partial Charity Care. Financial assistance may be denied when the patient or other responsible family representative does not meet the Financial Assistance Policy requirements.

Full Charity Care and Discount Partial Charity Care Reporting

TMMC will report actual charity care provided in accordance with regulatory requirements of the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, TMMC will maintain written documentation regarding its charity care criteria, and for individual patients, TMMC will maintain written documentation regarding all charity care determinations. As required by OSHPD, charity care provided to patients will be recorded on the basis of actual charges for services rendered.

TMMC will provide OSHPD with a copy of this Financial Assistance Policy which includes the Full Charity Care and Discount Partial Charity Care policies within a single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for Full Charity Care and Discount Partial Charity Care (See Addendum A for the application); and 3) the review process for both Full Charity Care and Discount Partial Charity Care. These documents shall be supplied to OSHPD every two years or whenever a significant change is made.

Charity care will be reported as an element of TMMC's annual Community Benefit Report submitted to OSHPD and any other appropriate state agencies.

PROCEDURES

Full Charity Care and Discount Partial Charity Care Eligibility: General Process and Responsibilities

Eligibility is defined for any patient whose family[2] income is less than 450% of the current FPL , if not covered by third-party insurance or if covered by third-party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account.

The TMMC Financial Assistance Program utilizes a single, unified patient application for both Full Charity Care and Discount Partial Charity Care. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The financial assistance application provides patient information necessary for determining patient qualification by TMMC and such information will be used to qualify the patient or family representative for maximum coverage under the TMMC Financial Assistance Program.

Eligible patients may qualify for the TMMC Financial Assistance Program by following application instructions and making every reasonable effort to provide TMMC with documentation and health benefits coverage information so that TMMC may make a determination of the patient's qualification for coverage under the program. Eligibility alone is not an entitlement to coverage under the TMMC Financial Assistance Program. TMMC must complete a process of applicant evaluation and determine coverage before Full Charity Care or Discount Partial Charity Care may be granted.

The TMMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, TMMC will use a financial assistance application. All patients unable to demonstrate financial coverage by third-party insurers will be offered an opportunity to complete the financial assistance application. Uninsured patients will also be offered information, assistance and referral to government-sponsored programs for which they may be eligible. Insured patients who are unable to pay patient liabilities after their insurance has paid, or those who experience high medical costs, may also be eligible for financial assistance. Any patient who requests financial assistance will be asked to complete a financial assistance application.

Patients or their family representative may complete an application for the Financial Assistance Program. The application and required supplemental documents are submitted to the TMMC Business Office. This office is identified on the application instructions. TMMC will make reasonable efforts to obtain a completed financial assistance application and use all methods outlined in IRS regulation 501(r) to publicize this information, including but not limited to notification of financial assistance as a condition of admission; posting the plain language summary, the Financial Assistance Policy and the financial assistance application on its website; making hardcopies of the plain language summary, Financial Assistance Policy and application available upon admission; and accepting application information orally (If the application is completed orally, then the patient or family member must still sign the application and submit required documentation).

The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed prior to

[2] A patient's family is defined as: 1) For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and 2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent of caretaker relative.

service, during a patient stay, or after services are completed and the patient has been discharged. A patient has a minimum of 240 days following the first post-discharge billing statement to submit an application. However, accounts for which no financial assistance application has been received, or for which a partial application has been submitted, may be sent to collection no sooner than 120 days following the first post-discharge billing statement, as described in the TMMC Credit & Collection policy.

Completion of a financial assistance application provides:

- Information necessary for TMMC to determine if the patient has income sufficient to pay for services;
- Documentation useful in determining qualification for financial assistance; and
- An audit trail documenting TMMC's commitment to providing financial assistance.

However, a completed financial assistance application is not required if TMMC determines it has sufficient patient financial information from which to make a financial assistance qualification decision.

Upon receipt of a completed financial assistance application, TMMC will 1) promptly determine eligibility for financial assistance; 2) notify the individual in writing of eligibility and available assistance; 3) provide the basis for the determination; 4) suspend all collection actions (if applicable); 5) reverse all extraordinary collection actions (if applicable); 6) provide a statement of amounts owed (if applicable); and 7) refund any payments in excess of amounts owed unless such excess amount is less than $5 (if applicable).

TMMC will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.

A financial assistance determination will be made only by approved TMMC personnel according to the following levels of authority:

Business Office Director: Accounts less than $100,000
Chief Financial Officer: Accounts greater than or equal to $100,000 and less than $250,000
President/CEO: Accounts greater than or equal to $250,000

Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include:

- No insurance under any government-coverage program; other third-party insurer; or inadequate third-party insurance coverage
- Family income based upon tax returns and recent pay stubs
- Family size
- Qualifying monetary assets (checking, savings, stocks, bonds, money market and similar investments)

If the patient or family has a pending application for another health coverage program while applying for financial assistance, then the pending application for other health coverage program shall not preclude eligibility for the TMMC Financial Assistance Program.

Qualification

Qualification criteria are used in making each individual case determination for coverage under the TMMC Financial Assistance Program. Financial assistance will be granted based upon each individual determination of financial need in accordance with the Financial Assistance Program eligibility criteria contained in this Financial Assistance Program policy. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability, religion, or any other status granted legal protection under the law.

TMMC Financial Assistance Program qualification may be granted for Full Charity Care (100% free services) or Discount Partial Charity Care (charity care of less than 100%), depending upon the patient or family representative's level of eligibility as defined in the criteria of this Financial Assistance Policy.

The patient and/or patient family representative who requests assistance in meeting their financial obligation to TMMC shall make every reasonable effort to provide information necessary for TMMC to make a financial assistance qualification determination. TMMC will provide guidance and/or direct assistance to patients or their family representative, as necessary, to facilitate completion of program applications. Completion of the financial assistance application and submission of any or all required supplemental information will be required for establishing qualification for the TMMC Financial Assistance Program, except in cases, where TMMC may make presumptive determinations of eligibility. Required supplemental supporting documents are listed in the financial assistance application.

TMMC Financial Assistance Program qualification is determined after the patient and/or patient family representative establishes eligibility according to criteria contained in this policy. While financial assistance shall not be provided on a discriminatory or arbitrary basis, TMMC retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.

Once determined, TMMC Financial Assistance Program qualification will apply to the specific services and service dates for which application has been made by the patient and/or patient family representative. Each separate encounter shall be singularly and separately determined on a case-by-case basis as to whether financial assistance qualification is met. However, in certain cases of continuing care relating to a patient diagnosis which requires on-going, related services, TMMC, at its sole discretion, may elect to treat continuing care as a single case for which qualification applies to all related on-going services provided by TMMC. Other pre-existing patient account balances outstanding at the time of qualification determination by TMMC will be included as eligible for write-off provided all financial and documentation requirements under this policy have been satisfied.

Patient obligations for Medi-Cal/Medicaid share of cost payments will not be waived under any circumstance. However, after collection of the patient share of cost portion, any other unpaid balance relating to a Medi-Cal/Medicaid share of cost patient may be considered for the TMMC Financial Assistance Program.

Amounts generally billed to patients receiving medically necessary care, who are at or below 450% of the FPL will not be more than Medicare would typically pay. TMMC uses the look-back method to determine amounts generally billed to patients who are eligible for financial assistance under this policy and expresses this amount as a percentage of billed charges. This percentage shall be updated at least annually and shall apply to all necessary hospital inpatient, outpatient and emergency services provided by TMMC. The rate is currently 12%.

Qualification: Full Charity Care and Discount Partial Charity Care

Qualification for Full Charity Care or Discount Partial Charity Care shall be determined solely by the patient's and/or patient family representative's ability to pay.

Full Charity Care and Discount Partial Charity Care Income Qualification Levels

1. Full Charity Care: If the patient's family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, then the entire (100%) patient liability portion of the bill for services will be written off.

2. Discount Partial Charity Care: If the patient's family income is between 201% and 450% of the established poverty income level, based upon current FPL Guidelines, and monetary assets are less than $10,000, and the patient meets all other Financial Assistance Program qualification requirements, then the following will apply:

    - Patient's care is not covered by a payer. If the services are not covered by any third-party payer so that the patient ordinarily would be responsible for the full-billed charges, then the patient's payment obligation will be the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary.

    - Patient's care is covered by a payer. If the services are covered by a third-party payer so that the patient is responsible for only a portion of the billed charges (i.e. a deductible or co-payment), then the patient's payment obligation will be an amount equal to the difference between what insurance has paid and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary. If the amount paid by insurance exceeds what Medicare would have paid, then the patient will have no further payment obligation.

    In either case, if a patient's responsibility is 10% or more of the patient's family income for the previous 12 months, then the entire amount owed by the patient will be limited to 10% of their family income for the preceding 12 month period.

    Any financial assistance will be reduced by monetary assets remaining after the following exclusion is applied: The first $10,000 of a patient's monetary assets, and 50% of a patient's monetary assets over the first $10,000 shall be excluded and not considered for financial assistance.

Qualification: Presumptive Eligibility

TMMC understands that certain patients may be unable to complete a financial assistance application, comply with requests for documentation, or are otherwise nonresponsive to the application process. As a result, there may be circumstances under which a patient's qualification for financial assistance is established without completing the formal assistance application. Under these circumstances, TMMC may utilize other sources of information to make an individual assessment of financial need. This information will enable TMMC to make an informed decision on the financial need of non- responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

TMMC may utilize a third-party to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The electronic technology is designed to assess each patient to the same standards and is calibrated against historical approvals for TMMC financial assistance under the traditional application process.

The electronic technology will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows TMMC to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy.

When electronic enrollment is used as the basis for presumptive eligibility, the discount whether full or partial will be granted for eligible services for retrospective dates of service only. If a patient does not qualify under the electronic enrollment process, then the patient may still be considered under the traditional financial assistance application process. For patients that do not qualify through this process, TMMC will provide them with a written notice informing them that financial assistance is available.

Patients whose accounts are determined to be presumptively eligible for Full Charity Care, will not be notified of their qualification . Their qualified accounts will be reclassified under the Financial
Assistance Policy as charity care; they will not be sent to collection; they will not be subject to further
collection actions; and they will not be included in
TMMC's bad debt expense.

Patients whose accounts are determined to be presumptively eligible for Discount Partial Charity Care shall receive the following:

- A notification informing the patient of the basis for the presumptive eligibility determination.
- Information on how the patient or their family may apply for more generous assistance.
- At least an additional 120 days in which to apply for more generous financial assistance before being sent to collection. TMMC shall not initiate extraordinary collection actions

for at least 240 days following the first billing statement. Notwithstanding the foregoing, TMMC shall not send any account to collections without first providing 30 days' notice of intent to initiate collection actions and shall make reasonable efforts to notify the patient of financial assistance programs.

- A bill indicating the amount due after applying all applicable charity discounts.

Upon receipt of a completed application, in which the patient applies for more generous financial assistance, TMMC will make a timely determination and notify the patient of the final determination.

Special Circumstances

Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of a patient's net worth, monetary assets, income and expenses, prior to eligibility qualification for the TMMC Financial Assistance Program. Note that any financial assistance will be reduced by the remaining amount after the first $10,000 of a patient's monetary assets, and 50% of a patient's monetary assets over the first $10,000 have been excluded from consideration. Such financial assistance evaluations must be made prior to service completion by TMMC.

Additionally, homelessness shall be a condition for granting presumptive eligibility under this policy. If the patient is determined to be homeless, then he/she will be deemed eligible for Full Charity Care under the TMMC Financial Assistance Program.

Other Eligible Circumstances

TMMC deems those patients that are eligible for government-sponsored low-income assistance program (i.e. Medi-Cal/Medicaid, Managed Medi-Cal, Healthy Families, California Children's Services and any other applicable state or local low-income program) to be indigent. Therefore such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental program. For example, patients who qualify for Medi-Cal/Medicaid or Managed Medi-Cal, as well as other programs serving the needs of low-income patients (e.g. CHDP, Healthy Families, and CCS), where the program does not make payment for all services or days during a hospital stay, are eligible for Financial Assistance Program coverage. Under TMMC's Financial Assistance Policy, these types of non-reimbursed patient account balances are eligible for full write-off as charity care. Specifically included as charity care are charges related to denied stays, denied days of care, and non-covered services. All Treatment Authorization Request (TAR) denials and any lack of payment for non-covered services provided to Medi-Cal/Medicaid or Managed Medi-Cal and other patients covered by qualifying low-income programs, and other denials (e.g. restricted coverage) are to be classified as charity care.

The portion of Medicare patient accounts (a) for which the patient is financially responsible (i.e. co-insurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal/Medicaid, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:

- The patient is a beneficiary under Medi-Cal/Medicaid or another program serving the health care needs of low-income patients; or

- The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.

Any patient whose income exceeds 450% of the FPL and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients, who have high incomes, do not qualify for routine Full Charity Care or Discount Partial Charity Care. However, consideration as a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income, net worth and monetary assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds $100,000 may be considered for eligibility as a catastrophic medical event.

Dispute Resolution

In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with TMMC. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.

Any or all appeals will be reviewed by the Business Office Director. The Business Office Director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the Business Office Director shall provide the patient with a written explanation of findings and determination.

In the event that the patient believes a dispute remains after consideration of the appeal by the Business Office Director, the patient may request in writing, a review by the Chief Financial Officer. The Chief Financial Officer shall review the patient's written appeal and documentation, as well as the findings of the Business Office Director. The Chief Financial Officer shall make a determination and provide a written explanation of findings to the patient. All determinations by the Chief Financial Officer shall be final. There are no further appeals.

Payment Plans

When a determination of Discount Partial Charity Care has been made by TMMC, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled term payment plan.

TMMC will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon the patient's ability to effectively meet the payment terms and shall take into account the patient's family income and essential living expenses. As a general guideline, payment plans will be structured to last no longer than 12 months. TMMC shall negotiate in good faith with the patient; however there is no obligation to accept the payment terms offered by the patient. If TMMC and patient or patient's family cannot agree to the terms of a payment plan, then the monthly payment shall be based on 10% of the patient's family monthly income. No interest will be charged to the patient for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

Collection Agencies

TMMC will make every reasonable, cost-effective effort to communicate payment options and programs with each patient who receives services at TMMC. In the event that a patient or guarantor does not respond or communicate with TMMC to resolve an open account, TMMC may forward the account to its collection agency in accordance with TMMC's Credit and Collection Policy. Since the financial status of the patient is not known, the amount forwarded for external collection will be discounted 83% in accordance with TMMC's Uninsured Discount Policy. For purposes of this Financial Assistance Policy, the discount shall be treated as an uninsured discount at the time the account is sent to collections. TMMC's external collection agencies may adjust the amount further should the patient's financial status become known and the patient qualifies for financial assistance. The collection agency shall make efforts to collect only this reduced amount.

Information gathered during collection agency collection efforts will be used to make presumptive eligibility determinations, based upon criteria set forth in this policy. Any account returned to TMMC from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill will be deemed eligible for charity care. Documentation of the patient or family representative's inability to pay for services will be maintained in the charity care documentation file. Additionally, amounts previously written off to uninsured discount for that account will be reversed and treated as charity.

All accounts returned from a collection agency for re-assignment from bad debt to charity care will be evaluated by TMMC Business Office personnel prior to any re-classification within TMMC's accounting system and records.

How to Apply for Financial Assistance

Financial assistance will only be granted to patients that require emergent or medically necessary treatment. Financial assistance applications, plain language summaries, the Financial Assistance Policy and the Credit & Collections policy may be obtained, upon request, from the main admissions desk located in the main lobby of the Lundquist Tower; from the admissions desk located in the emergency room; from TMMC's Business Office; on TMMC's website (www.torrancememorial.org); by mailing requests to the address below; and by calling TMMC's Business Office at (310) 517-4765.

Assistance in completing the applications may be requested by contacting TMMC's Business Office, as noted above. Completed applications along with all required supporting documentation should be mailed to Torrance Memorial Medical Center, Business Office, 3330 Lomita Blvd, Torrance, CA 90505. The application will only be considered complete when all required documentation has been received.

Confidentiality

It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will

implement this policy should be guided by these values.

Good Faith Requirements

TMMC makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, TMMC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order to qualify.

For care deemed covered under this policy, TMMC will not 1) sell the individual's debt (with the possible, but unlikely, exception of certain circumstances permitted by law); 2) require payment of unpaid medical bills for previous financial-assistance-related care prior to the provision of medically necessary services; 3) defer or delay medically necessary care; 4) report adverse information to credit bureaus; or 5) require any legal processes.

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Initial Approvals and Major Revisions

Operations Committee: 10/16/02

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Reviewed Date(s): 06/04, 03/05, 8/05, 9/05, 09/14, 12/14, 11/15, 04/17, 7/18
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Board of Trustees: 12/14, 12/15, 4/17, 8/18

Distributed to: Administrative Policy & Procedure Manual (Finance)

Related Policies:
Credit & Collection Policy – Admin 100.05
Discount Policy – Admin 100.06

Addendum B
Physician Providers at Torrance Memorial Medical Center

Medical Specialty	Covered Under FAP	NOT Covered Under FAP
Anesthesiologists		X
Burn & Reconstructive Plastic Physicians	X	
Cardiologists		X
Dentisits		X
Dermatologists		X
Electrophysiologists/Interventiional Cardiologists		X
Emergency Physicians		X
Endocrinologists & Reproductive Endocrinologists		X
Gastroenterologists		X
General Practitioners, Family Practice, & PCPs		X
Geriatricians		X
Gynecologic Oncologists		X
Hospitalists		X
Immunologist (and Allergies)		X
Infectious Disease		X
Internal Medicine		X
Neonatologists	X	
Nephrologists		X
Neurologists & Neuro Surgeons		X
OB/GYN & Laborists		X
Oncologists/Hematologists		X
Opthamologists		X
Orthopedists		X
Otolarygologists		X
Pain Management		X
Palliative Care Physicians		X
Pathologists	X	
Pediatric sub specialists - ALL Disciplines		X
Pediatrics		X
Perintologists		X
Physical Medicine & Rehab		X
Podiatrist		X
Psychiatrists		X
Psychologists		X
Pulomonologists		X
Radiation Oncologists	X	
Radiologists	X	
Rheumatologists		X
Surgeons - All (All Disciplines & Specialties)		X
Urologists		X