Unique Identifier: HWP12027	DAY KIMBALL HOSPITAL Hospital-Wide Policy Manual Section – Leadership Page 1 of 5
TITLE: Charity Care/Financial Assistance	RESPONSIBLE PARTY (IES): Director of Revenue Cycle Vice President and CFO
FORMERLY KNOWN AS: Charity Free Care	
EFFECTIVE: 1/99	REVISED: 2/02, 1/03, 11/1/04, 2/1/05, 5/2/05, 10/16/06, 3/21/07, 3/1/08, 5/1/10
REVIEWED:	
REGULATORY STANDARD:	

I. GENERAL STATEMENT OF PURPOSE:

It is the philosophy and policy of Day Kimball Hospital that medically necessary health care services should be available to all individuals regardless of their ability to pay. The policy has been written in accordance with Section 9007 of the Patient Protection and Affordable Care Act (Act), signed into law on March 23, 2010, which adds new sections 501(r) and 4959 to the Internal Revenue Code. Section 501(r) includes a series of specific requirements for hospitals to receive and maintain Section 501(c)(3) ("tax exempt") status.

II. POLICY STATEMENT:

Day Kimball Hospital's Patient Accounts Department will maintain procedures to assist both uninsured and underinsured patients with meeting their financial obligations to the hospital.

III. POLICY:

A. Uninsured Patients

1. Day Kimball Hospital may not collect from uninsured patients, who meet the definition as outlined in Connecticut State Statute 19a-673 more than the cost of providing services. DKH will adhere to the framework and guidelines set-forth by the Connecticut Hospital Association on the Statewide Discount Policy for Uninsured Patients.

   Statute 19a-673 states: "No hospital that has provided health care services to an uninsured patient may collect from the uninsured patient more than the cost of provided services. Cost of providing services means a hospital's published charges multiplied by the hospital's most recent relationship of cost to charges as taken from most recent audited financials that have been filed with OHCA."

2. All DKH patients who are found to have no insurance for a given date of service will have their associated charges adjusted to the hospital's cost by using the most recently filed cost to charge ratio reported to the State of Connecticut Office of Health Care Access.

3. Charity Care Eligibility for the Uninsured

   Uninsured patients who show proof of denial from the State of Connecticut DSS office may qualify for a 75% charity care discount to the cost of their care if they meet **all** of the following criteria:

   a. **Single account balance of $250 or greater OR accounts spanning six months totaling $500 or greater (individual) OR accounts spanning six months totaling $1000 or greater for 2 or more family members (under same guarantor).**

   b. Annual income is less than 250% of the current Federal Income Poverty Level (FPL).

   c. Liquid assets must not exceed $10,000 (includes stocks, bonds, cash, 401K, IRA, CD, property and business value, and recreational vehicles).

   DKH will consider the total medical expenses faced by an uninsured family and the family's ability to pay for those expenses, and offer greater assistance when possible to those individuals or families facing catastrophic medical expenses.

B. Insured Patients

1. Insured patients may qualify for a 75% charity care discount on the remaining **uncovered cost** of their care after insurance payments are made if they meet all of the following criteria:

   a. Single account balance of $250 or greater OR accounts spanning six months totaling $500 or greater (individual) OR accounts spanning six months totaling $1000 or greater for 2 or more family members (under same guarantor).

   b. Annual income is less than 250% of the current Federal Income Poverty Level (FPL).

   c. Liquid assets must not exceed $10,000 including (Stocks, bonds, cash, 401, IRA, CD, property and business value and recreational vehicles).

Cost is calculated by applying the hospital's reported cost to charge ratio per statute 19a-673 to the total charges. Any portion of the insurance payment(s) that does not cover the calculated cost (uncovered cost) will be eligible.

C. Processing Guidelines:

1. All self-employed applications must submit the entire tax return including all schedules as well as the most recent P&L statement. The Director of Revenue Cycle or designee will review these documents to determine income.

2. Notification of charity care determinations will be mailed to the patient/guarantor within 30 days of receipt of completed application.

D. Notification to Patients

1. Signage indicating the availability of charity care is posted in English and Spanish in Patient Accounts, Patient Access, the Lab, Physician Practices and Satellite locations. Summaries of additional programs are available on the DKH website.

2. Patient Financial Advocates will attempt to visit all non-psychiatric inpatients registered as self-pay at a point in time deemed appropriate by the clinical care providers attending to a given patient. Patient Financial Advocates will work to assist them in either securing a payment source or, as a last resort, assisting them with the DKH Charity Care Application process and guidelines.

3. Psychiatric inpatients will be counseled while in house for state application or charity care application assistance only.

4. A series of monthly statements will be sent to patients with a balance following discharge. Each statement will remind the patient of the availability of funding assistance through the hospital's charity care program if the eligibility criteria are met.

E. Gross Family Income

1. For the purpose of determining gross family income and qualifying accounts for charity care, the following rules apply:

   a. Family members are only immediate family members when they are the applicant, spouse, children under the age of 18 or students to the age of 25, and stepchildren under the age of 18 or students to the age of 25. Other dependents claimed on the federal income tax return may be considered.

   b. Unmarried couples do not qualify as a family unless tax returns are filed as married. Only the applicant's income will be looked at for qualification for funds and only the applicant's accounts will be awarded charity care funds if qualified.

F. Eligibility Determinations

The provision of health care should never be delayed pending an assistance eligibility determination.

1. Patients must be a Connecticut resident in order to qualify. Non-Connecticut residents will only be eligible for charity care if their services at Day Kimball Hospital were provided via the emergency room or through an emergency admission.

2. Day Kimball Hospital will make every attempt to conduct all charity care determinations within 30 days of receiving a completed charity care application.

3. Patients will have 30 days to complete a DKH charity care application. Failure to provide all required pieces of documentation within 30 days will deem the application incomplete. A letter of the hospital's intent to deny and close their application due to missing information will be mailed to the applicant at day 31. Applicants will be given another 14 calendar days grace period to provide all outstanding materials before the application will be terminated.

4. Application to the DKH Financial Assistance/Charity Care Program can be submitted up to six months after the provision of care and will be in effect for six months forward from the last date of service listed on the application at the time of approval.

5. Acceptable verification of income includes the following:

    a. Most recent federal tax return including all schedules when applicable along with at least one of the following:

        - Last 3 months payroll check stubs
        - Most recent P&L statement if self employed
        - Schedules C from tax return if self employed
        - Schedule E from tax return for other real estate or rental income
        - Written verification from employer verifying income for the last 3 months
        - Copies of any pension, alimony or other sources of income
        - Copies of social security earnings
        - Any other information felt to be pertinent

    b. If a patient claims that he/she does not submit a federal tax return or has lost their most recent tax return, we can require that they complete IRS form 4506-T (request for transcript of tax return). The patient can either request a copy of their federal tax return or a confirmation that they have not filed a federal tax return.

As charity care is the program of last resort, an application will not be considered until the applicant has been screened for other assistance programs and it has been validated that all other sources of payment have been exhausted.

6. In extenuating circumstances where the situation reasonably demonstrates that a financial hardship exists, Day Kimball Hospital may offer additional charity care at its own determination without a completed application. Either the Director of Revenue Cycle or the CFO must approve these requests. Example: homeless patients.

7. Applications will remain in effect for up to six months from date approved. Day Kimball may request updated financial information at any time during the period and adjust accordingly.

8. Day Kimball Hospital reserves the right to change benefit determination if financial circumstances have changed. The patient or guarantor will be notified in writing when this occurs (within 7 business days from date of change).

9. Falsification of application will result in the prospective or retrospective denial of charity care benefits.

G. Appeals

1. Responsible parties may appeal a charity care determination by providing additional information, such as insurance verification or an explanation of extenuating circumstances to Patient Accounts within 30 days of receiving notification.

2. First Level of Appeal should be made to the Director of Revenue Cycle who will review the appeal and the responsible party will be notified of the appeals outcome.

3. Second Level of Appeal should be made to Administration (CEO, CFO, or CNO) who will review the appeal and the responsible party will be notified of the appeals outcome.

H. Financial Assistance Balance Approval Guidelines

Approvals will be as follows:

- Balances up to $10,000.00 will be approved by the Patient Accounts Manager or the Patient Accounts Administrative Assistant.
- Balances between $10,001.00 to $20,000.00 will be approved by the Director of Revenue Cycle.
- Balances above $20,000.00 will be approved by the Vice President and CFO.

Bristol Hospital
Fee Schedule as of 2/3/09
@ 1 Times Poverty Guidelines

For family size over 8 add: **$3,740**

Family Size	Annual Gross Family Income From	Annual Gross Family Income To	Weekly Gross Family Income From	Weekly Gross Family Income To	Percentage of Free Care
1	$0	$10,829	$0	$208	100%
	$10,830	$12,032	$209	$231	90%
	$12,033	$13,236	$232	$255	80%
	$13,237	$14,439	$256	$278	70%
	$14,440	$15,642	$279	$301	60%
	$15,643	$16,846	$302	$324	50%
	$16,847	$18,049	$325	$347	40%
	$18,050	$19,252	$348	$370	30%
	$19,253	$20,456	$371	$393	20%
	$20,457	$21,660	$394	$417	10%
2	$0	$14,569	$0	$280	100%
	$14,570	$16,188	$281	$311	90%
	$16,189	$17,807	$312	$342	80%
	$17,808	$19,426	$343	$374	70%
	$19,427	$21,045	$375	$405	60%
	$21,046	$22,663	$406	$436	50%
	$22,664	$24,282	$437	$467	40%
	$24,283	$25,901	$468	$498	30%
	$25,902	$27,520	$499	$529	20%
	$27,521	$29,140	$530	$560	10%
3	$0	$18,309	$0	$352	100%
	$18,310	$20,343	$353	$391	90%
	$20,344	$22,378	$392	$430	80%
	$22,379	$24,412	$431	$469	70%
	$24,413	$26,447	$470	$509	60%
	$26,448	$28,481	$510	$548	50%
	$28,482	$30,516	$549	$587	40%
	$30,517	$32,550	$588	$626	30%
	$32,551	$34,585	$627	$665	20%
	$34,586	$36,620	$666	$704	10%

Bristol Hospital
Fee Schedule as of 2/3/09
@ 1 Times Poverty Guidelines

For family size over 8 add: **$3,740**

	Annual Gross Family Income		Weekly Gross Family Income		Percentage of Free Care
	From	To	From	To	
4	$0	$22,049	$0	$424	100%
	$22,050	$24,499	$425	$471	90%
	$24,499	$26,949	$472	$518	80%
	$26,949	$29,399	$519	$565	70%
	$29,399	$31,849	$566	$612	60%
	$31,849	$34,299	$613	$660	50%
	$34,299	$36,749	$661	$707	40%
	$36,749	$39,199	$708	$754	30%
	$39,199	$41,649	$755	$801	20%
	$41,649	$44,100	$802	$848	10%
5	$0	$25,789	$0	$496	100%
	$25,790	$28,655	$497	$551	90%
	$28,656	$31,520	$552	$606	80%
	$31,521	$34,386	$607	$661	70%
	$34,387	$37,251	$662	$716	60%
	$37,252	$40,117	$717	$771	50%
	$40,118	$42,982	$772	$827	40%
	$42,983	$45,848	$828	$882	30%
	$45,849	$48,713	$883	$937	20%
	$48,714	$51,580	$938	$992	10%
6	$0	$29,529	$0	$568	100%
	$29,530	$32,810	$569	$631	90%
	$32,811	$36,091	$632	$694	80%
	$36,092	$39,372	$695	$757	70%
	$39,373	$42,653	$758	$820	60%
	$42,654	$45,935	$821	$883	50%
	$45,936	$49,216	$884	$946	40%
	$49,217	$52,497	$947	$1,010	30%
	$52,498	$55,778	$1,011	$1,073	20%
	$55,779	$59,060	$1,074	$1,136	10%

Bristol Hospital
Fee Schedule as of 2/3/09
@ 1 Times Poverty Guidelines

For family size over 8 add: **$3,740**

	Annual Gross Family Income		Weekly Gross Family Income		Percentage of Free Care
	From	To	From	To	
7	$0	$33,269	$0	$640	100%
	$33,270	$36,966	$641	$711	90%
	$36,967	$40,662	$712	$782	80%
	$40,663	$44,359	$783	$853	70%
	$44,360	$48,056	$854	$924	60%
	$48,057	$51,752	$925	$995	50%
	$51,753	$55,449	$996	$1,066	40%
	$55,450	$59,146	$1,067	$1,137	30%
	$59,147	$62,842	$1,138	$1,209	20%
	$62,843	$66,540	$1,210	$1,280	10%
8	$0	$37,009	$0	$712	100%
	$37,010	$41,121	$713	$791	90%
	$41,122	$45,233	$792	$870	80%
	$45,234	$49,346	$871	$949	70%
	$49,347	$53,458	$950	$1,028	60%
	$53,459	$57,570	$1,029	$1,107	50%
	$57,571	$61,682	$1,108	$1,186	40%
	$61,683	$65,795	$1,187	$1,265	30%
	$65,796	$69,907	$1,266	$1,344	20%
	$69,908	$74,020	$1,345	$1,423	10%

Statement of Collection Policy

Failure to make payment for services rendered, in accordance with the financial policies of Bristol Hospital, will result in referral to an outside collection agency. Collection action will be taken by the agency, on behalf of the Hospital, to secure payment, not excluding legal action when appropriate.

COLLECTION POLICY AND PROCEDURE

TO: BILLING OFFICE STAFF

RE: REQUESTED INFORMATION RECEIVED FROM INSURANCE CARRIERS FOR INFORMATION NEEDED DIRECTLY NEEDED FROM THE INSURED.

WHEN BILLERS RECEIVE NOTICE FROM INSURANCE COMPANIES THAT THE ACCOUNT WILL BE PENDING DUE TO MISSING OR NEEDED INFORMATION DIRECTLY FROM THE INSURED PARTY, THE BILLER WILL DOCUMENT THIS IN CNI AND A COPY OF THIS INFORMATION WILL BE SUBMITTED TO THE COLLECTION RECEIVABLE MANAGER.

THE COLLECTION RECEIVABLE MANAGER IS RESPONSIBLE FOR CONTACTING THE INSURED BY TELEPHONE TO INFORM THE INSURED THAT THEY MUST CONTACT THEIR INSURANCE COMPANY.

PLEASE NOTE THIS DOES NOT INCLUDE THE AUTO AND LIABILITY CLAIMS THAT ARE SUBMITTED BY THE BILLERS DIRECTLY TO OUR COLLECTOR ESTHER HEBERLE FOR FOLLOW-UP.

EFFECTIVE: MARCH 23, 2007

Rev. 12,10

CREDIT COLLECTION

Detailed Follow-up Procedure

In-Pt/Out Pt/Hospital I & II
Uninsured/self pay accounts

TIME FRAME:	ACTION	RESPONSIBILITY
First week of each month "Pending W/O to B/D report. 60 days w/out activity (COMENU-ARAD)		CREDIT MNG

Receipt of report from Data to Credit Rep — CREDIT REP.

Credit Rep researches each account via the system using:

a. CNI- checking for notes as to why acct should not go to collection
b. ARPT-at least two statements have been previously sent to guarantor all Insurance's have been billed, amounts owed are in the correct buckets.
c. Guarantor Inquiry- No payments have been received within 60 days, No credits are due on guarantor.
d. PLM2- Accounts going to collection. Change/review correct agency code to be sent to agency.

Removing accounts not being sent a Final Letter — CREDIT REP.

a. PLM2- (Pending Letter Maintenance) delete this record- **YES**
b. WOBDM (Write off Bad Debt Maintenance) delete from B/D file- **YES**

Final Notices are produced by the 18th of the month. — DATA

a. The Credit Mng will contact Data(produces letters) and Payroll(they mail The Final Notices
b. The Final Notice Letters are reviewed and duplicates are mailed manually by Credit Rep.

End of Month W/O to Bad Debt

a. All accounts that received a Final Notice Letter are Placed in B/D (WOMENU-Update W/O to B/D — CREDIT MNG
c. Files are produced on tape and sent to appropriate collection agency Within first/second week of the month.

Revised: 10/02/2002
Rev. 3-4 Mark
Rev. 2-8 Mark
Rev 12-10 Mark

PATIENT PAYMENT PLAN
PROCEDURE

When a Guarantor/Patient requests a monthly Payment Plan on their open balance accounts the following procedure will be followed.

a. Payment Plan is set up so the balance owed will paid within least amount of time. Credit Collection Rep will have the Guarantor/Patient complete a Payment Plan form and a copy of the form is saved in the In-Pt Collector's office.

b. A revised Payment Plan will need to be setup with the Guarantor/Patient if there is still outstanding accounts or new accounts unpaid from one year of the original Payment Plan.

c. Payment Plans will be voided if payments are not received timely.

d. Payment Plans may not be less then $35.00 monthly without the Pt Directors signature.

Procedure for Payment Plans

a.. CNI- each account listed under the Payment Plan agreement will be documented in Collection Note Inquiry by the Credit Rep.

e. Under Collection Menu (BHCM) the payment plan will be entered.(PPM)

f. If there is a broken Payment Plan, Credit Rep will delete the Payment Plan and inform the Guarantor/Patient (PPM). This action will remove the Payment Plan from the monthly statement to the Guarantor/Patient.

Revised: 10/02/2002

Rev. 3.4 Mark

Rev 2.8 Mark

Rev 12 10 Mark

COLLECTION AGENCY PLACEMENT PROCEDURE POLICY

Perform Collection Agency Placement Procedure for agencies as follows:
10% of total amount placed is sent to American Adjustment Bureau only.
90% of Collection Placement is sent to Medconn Collection Agency.

HOSP I

UNDER BH CUSTOM WRITE OFF MENU (UMENUWO) SELECT #40(MEDCONN CREATE DISKETTE) AND #41(BH CREATE AMERICAN ADJ DISKETTE) ENTER WRITE OFF TO BAD DEBT DATE AND ENTER. CALL I.S. (INFORMATION SERVICES) TO PRINT LAST PAGE OF REPORT X2 AND DISKETTS) (DATE THAT IS ENTERED IS THE DATE OF THE END OF THE MONTH CLOSING)

HOSP II

SAME PROCEDURE AS HOSP I LISTED ABOVE BUT ONLY #40 (MEDCONN CREATE DISKETTE) IS REQUESTED.

Last page of Write to BD is sent to the agencies with diskette. Pt Receivable Mng enters the total accounts and dollars into an excel spreadsheet names FACCTSPL4 (number changes each new Fiscal Yr)

At the end of the Fiscal Year, the excel FACCTSPL sheet is emailed to the hospital control officer.

This procedure is performed during the end of the first week of each month.

Reviewed Dec 2007
Marylou Horvath

Rev. 12.08

Rev 12.10

COLLECTION EXHAUSTED EFFORTS

POLICY AND PROCEDURES

STEP:

1. **COLLECTION AGENCY WILL RETURN ACCOUNTS TO HOSPITAL QUATERLY THAT ARE NO LONGER COLLECTABLE.**

2. **IN HOSPIAL SYSTEM UNDER A/R PAYOR TRANSFER (ARPT) CHANGE COLLECTION AGENCY CODE TO EITHER (20) OR (19) MEDICARE ACCOUNTS WITH PT CO PAY/DED ONLY.**

3. **BEFORE COMPLETING W/O FROM BAD DEBT FUNCTION RUN OPTION 11 W/O FROM BAD DEBT SELECTION (W/OFBDS) FOR REIMBURSEMENT REPORT TO MEDICARE ON ONLY AGENCY (19).**

3. **TO REMOVE FROM BAD DEBT FILE TAKE OPTION 14 (UW/OFBD) ****CHOOSE ONLY EITHER AGENCY CODE 19 AND/OR 20***. NEVER LEAVE BLANK OR ENTER ANY OTHER AGENCY CODE OR BALANCES WILL BE PURGED FROM BAD DEBT FILE.**

4. **ANY RECOVERIES ON PURGED BAD DEBT ACCOUNTS ARE EITHER REINSTATED UNDER (RAA) FUNCTION OR PLACED IN " RECOVERY TO BAD/DEBT "BY ACCOUNTS RECEIVABLE DEPARTMENT.**

5. **OTHER REASONS FOR W/O BAD DEBT ACCOUNTS ARE AS FOLLOWS: BANKRUPTCY ACCOUNTS, NO ESTATE, BRISTOL HOSPITAL SETTLEMENTS (ONLY WITH DIRECTORS APPROVAL)**

Reveiwed Mar 04

Rev 2.08

Rev 12-10

SMALL BALANCE W/O PROCEDURE

THIS PROCEDURE IS USED TO AUTOMATICLY SELECT SMALL BALANCES THAT ARE $9.99 AND UNDER FROM THE ACTIVE A/R. ***FOLLOW THE STEPS BELOW UNDER HOSPITAL I, II AND III.***.
****PLEASE NOTE SMALL BALANCE CREDITS WILL NOT APPEAR ON THIS SMALL BALANCE W/O LIST. ALL CREDITS ARE FOLLOWED- ON UP BY THE ACCOUNT RECEIVABLE DEPARTMENT.**

1. OPTION 21 TO CLEAR OUT FILE CB/DSBWF
   ENTER OPTION #1 (SM BALANCE W/O FILE)
   AND ENTER

2. OPTION 16 (PENDING SM BAL. W/O LIST
   DATE STAYS TO TODAYS DATE
   PRINTER NAME: QPRINT
   CALL I.S. TO PRINT REPORT

3. OPTION 19 (UPDATE SM BAL. W/O LIST
   CALL I.S TO PRINT UPDATED REPORT AND SAVE
   TO LASER VAULT.

EFFECTIVE: 9/18/1997
Lin Pierce

Rev. Mark 3.4

Rev 2.8 Mark

Rev 12.10 Mark

W/O OR REINSTATEMENT FROM B/D PROCEDURE

This is used to transfer a balance back to the active A/R that had already been placed onto the B/D side of the system. It can also be used to transfer a balance from the A/R to B/D.

Select option # 26 (W/O or Reinstate Acct Balances) from the Bristol Hospital Write Off Menu.

The following screen will appear.

- Acct # number of the account who's balance is to be transfered .
- Type enter a R if the balance of the account is to be transfered from B/D to the
  enter a B if the balance of the account is to be transfered from the A/R to B
- Item # enter the CDM 990 5257 this number is for General ledger reporting
- Date enter todays date for accounts being reinstated to the A/R.
- press enter
- print screen
- press CMD 6 to record this information into the online system.

Rev. 3.4 Mark

Rev 3.8 Mark

Rev 12 10 Mark

UNCOLLECTABLE W/O PROCEDURES

ITEMS THAT MAY FALL UNDER WRITE OFFS:

UNCOLLECTABLE-TIMELY FILING	**990 8050**
UNCOLLECTABLE-NON COV/REIM	**990 9782**
UNCOLLECTABLE-TO OLD TO BILL	**990 8060**
UNCOLLECTABLE-NO REFERRAL	**990 8065**
UNCOLLECTABLE-BANKRUPTCY	**990 8070**
UNCOLLECTALBE-NO ESTATE	**990 5249**
SMALL BALANCE W/O	**990 5252**

BEFORE MONTH END ANY ACCOUNTS THAT QUALIFY FOR THE ABOVE TYPE WRITE OFF IS SUBMITTED TO THE PATIENT RECEIVABLE MANAGER TO REVIEW. THE ACCOUNT IS THEN, SUBMITTED TO THE DIRECTOR OF THE BUSINESS OFFICE BY THE PT REC MNG FOR HER APPROVAL. SHE WILL SIGN HER AUTHORIZATION BEFORE THE ACCOUNT MAY BE WROTE- OFF AS UNCOLLECTABLE.

THE PT. REC. MANAGER WILL ADJUST OFF THE ACCOUNT UNDER "MCP" MISCELLANOUS CHARGE POSTING". ALWAYS PRINT THE SCREEN BEFORE F3 ACCEPT. COPIES OF ALL WRITE OFFS ARE FILED IN THE TWO PT RECEIVABLE MANAGERS OFFICE.

PT RECEIVABLE MANAGER: MARYLOU HORVATH Jennifer Salomone

Rev Cycle Dir. Maria Simone

REVIEWED 2/~~05~~ 08

Reviewed 12.10

BRISTOL HOSPITAL, INC. BREWSTER RD. BRISTOL CT 06010

MEDICARE BAD DEBT MORTATORIUM AND CLARIFICATION OF BAD DEBT POLICY

DATE: 3/9/07

TO: MEDICARE PART A PROVIDER AUDIT

THE COLLECTION POLICY IN EFFECT ON AUGUST 1,1987, WAS EXPLICITLY APPROVED BY THE FI AND THE POLICY HAS NOT CHANGED FOR THE SUBSEQUENT CORRESPONDING COST REPORT PERIODS.

ATTACHMENT:
BRISTOL HOSPITAL'S MEDICARE BAD DEBT POLICY AND PROCEDURES.

Rec 2.8
Reviewed 12.10

PROCEDURE

MEDICARE BAD DEBT COLLECTION AGENCY/STATE B/D REPORTING

MEDICARE CLAIMS WILL BE REVIEWED AND SELECTED FROM SERIES BASED ON DATE AGENCY RETURNED ACCOUNTS TO THE HOSPITAL AS 'EXHAUSTED EFFORTS' AND DATE STATE SECONDARY UNPAID BALANCE WAS WROTE OFF FROM SERIES.

#1 COLLECTION AGENCY RETURNED EXHAUSTED EFFORT ACCOUNTS:

Series will select all Medicare Collection Agency Returned accounts following CMS Federal Guidelines (413.178 Bad Debts). These accounts will be identified from the Collection Agency Return report and our agency code (19-exhusted efforts). Accounts will be selected under menu option 32 . Printer name is: CATAPULT1. Accounts are selected and emailed to the Pt Receivable Manager. Accounts are reviewed again to ensure they may be placed on the Medicare B/D Cost Report. Once accounts are reported they are removed from Series as Write Off from Bad Debt.

#2 MEDICARE STATE SECONDARY UNPAID BALANCES:

Accounts are selected by Series adjustment code #990-5207 Medicaid Cross-Over Write-off and date Cross-over was posted from the State Remittance. Option 33 from our Series Menu is run under printer name: CATAPULTI. Accounts are selected and emailed to Pt Receivable Manager. Accounts are reviewed to ensure they may be placed on the Medicare B/D Cost Report.

The Excel Spreadsheets are maintained and saved on the PT Receivable Managers PC and totals are submitted to Reimbursement Quarterly.

Reporting is by Fiscal Year.

Effective Aug 1,1987
Reviewed: Jan 1995
Reviewed: Mar 2004
Reviewed: Mar 2007
Reviewed: Jan 2008
Reviewed 12.10

(b) If the beneficiary has not incurred the full deductible applicable under Part B of Medicare before the dialysis treatment, the intermediary subtracts the amount applicable to the deductible from the facility's prospective rate and pays the facility 80 percent of the remainder, if any.

§ 413.178 Bad debts.

(a) CMS will reimburse each facility its allowable Medicare bad debts, as defined in § 413.80(b), up to the facility's costs, as determined under Medicare principles, in a single lump sum payment at the end of the facility's cost reporting period.

(b) A facility must attempt to collect deductible and coinsurance amounts owed by beneficiaries before requesting reimbursement from CMS for uncollectible amounts. Section 413.80 specifies the collection efforts facilities must make.

(c) A facility must request payment for uncollectible deductible and coinsurance amounts owed by beneficiaries by submitting an itemized list that specifically enumerates all uncollectable amounts related to covered services under the composite rate.

§ 413.180 Procedures for requesting exceptions to payment rates.

(a) *Outpatient maintenance dialysis payments.* All payments for outpatient maintenance dialysis furnished at or by facilities are made on the basis of prospective payment rates.

(b) *Criteria for requesting an exception.* If a facility projects on the basis of prior year costs and utilization trends that it will have an allowable cost per treatment higher than its prospective rate set under § 413.174, and if these excess costs are attributable to one or more of the factors in § 413.182, the facility may request, in accordance with paragraph (d) of this section, that CMS approve an exception to that rate and set a higher prospective payment rate. However, a facility may only request an exception or seek to retain its previously approved exception rate when authorized under the conditions specified in paragraphs (d) and (e) of this section.

(c) *Application of deductible and coinsurance.* The higher payment rate is subject to the application of deductible and coinsurance in accordance with § 413.176.

(d) *Payment rate exception request.* A facility must request an exception to its payment rate within 180 days of—

(1) The effective date of its new composite payment rate(s);

(2) The effective date that CMS opens the exceptions process; or

(3) The date on which an extraordinary cost-increasing event occurs, as specified (or provided for) in §§ 413.182(c) and 413.188.

(e) *Criteria for retaining a previously approved exception rate.* A facility may elect to retain its previously approved exception rate in lieu of any composite rate increase or any other exception amount if—

(1) The conditions under which the exception was granted have not changed;

(2) The facility files a request to retain the rate with its fiscal intermediary during the 30-day period before the opening of an exception cycle; and

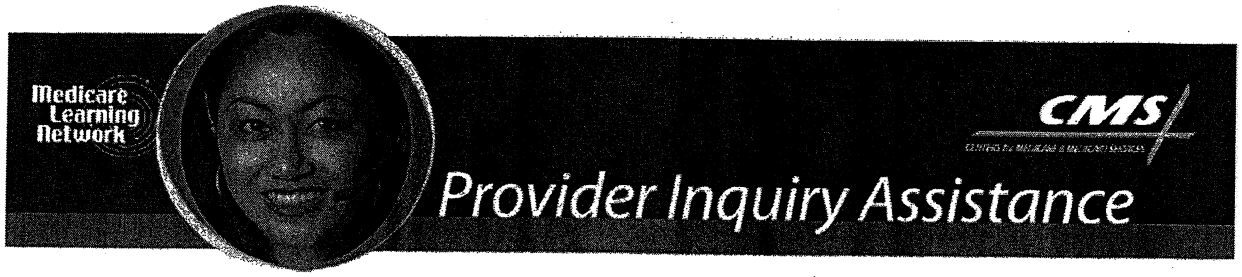
(3) The request is approved by the fiscal intermediary.

(f) *Documentation for a payment rate exception request.* If the facility is requesting an exception to its payment rate, it must submit to CMS its most recently completed cost report as required under § 413.198 and whatever statistics, data, and budgetary projections as determined by CMS to be needed to adjudicate each type of exception. CMS may audit any cost report or other information submitted. The materials submitted to CMS must—

(1) Separately identify elements of cost contributing to costs per treatment in excess of the facility's payment rate;

(2) Show that the facility's costs, including those costs that are not directly attributable to the exception criteria, are allowable and reasonable under the reasonable cost principles set forth in this part;

(3) Show that the elements of excessive cost are specifically attributable to one or more conditions specified in § 413.182;



Clarification of Medicare Bad Debt Policy Related to Accounts at a Collection Agency – JA0824

Related CR Release Date : N/A

Date Job Aid Revised: July 8, 2008

Effective Date: N/A

Implementation Date: N/A

Key Words	SE0824, Debt, Collection
Contractors Affected	• Part A/B Medicare Administrative Contractors (A/B MACs) • Fiscal Intermediaries (FIs)
Provider Types Affected	All fee for service hospital and non-hospital providers who bill Medicare FIs or A/B MACs and are eligible to claim bad debt for Medicare beneficiaries

In order for providers to properly claim a bad debt and be reimbursed under the Medicare Program, providers must follow all of the *Criteria for Allowable Bad Debt* set out at 42 Code of Federal Regulations (CFR) § 413.89(e).

Pursuant to those criteria, a provider must establish that reasonable collection efforts were made. A provider must establish that the debt is uncollectible when claimed as worthless and use sound business judgment to establish that there is no likelihood of recovery at anytime in the future.

Provider Needs to Know...

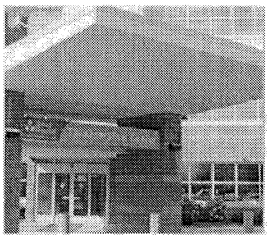
- Until a provider's reasonable collection effort (including the use of a collection agency as well as in-house efforts) has been completed, a Medicare bad debt may not be deemed as uncollectible.
- Section 310.2 of the *Provider Reimbursement Manual (PRM)*, "Presumption of Noncollectibilitiy", provides that, "If after reasonable and customary attempts to collect a bill, the debt remains unpaid for more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible." However, Section 310.2 must be read within the context of the regulations and Section 310.
- As noted above, the manual makes it clear that the Centers for Medicare & Medicaid's (CMS) deems the use of a collection agency to be part of the provider's ongoing collection effort, and as long as the debt remains with a collection agency (even if more than 120 days), the debt cannot be deemed "uncollectible."

	• Therefore, in accordance with the regulation/policy in effect prior to the moratorium, effective August 1, 1987, until a provider's reasonable collection efforts have been completed, including both in-house efforts and the use of a collection agency, unpaid deductible and coinsurance amounts cannot be recognized as a Medicare bad debt.
Background	• It has been a CMS longstanding policy that when an account is in collection, a provider cannot have determined the debt to be uncollectible and cannot have established that there is no likelihood of recovery under the regulations found at 413.89(e) (See 31 FR 14813; published November 22, 1966), and in Chapter 3 of the PRM. • Section 310.A of the PRM explicitly states that, "A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone, and personal contacts."
Operational Impact	N/A
Reference Materials	The related MLN Matters article can be found at ***http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0824.pdf*** on the CMS website. The regulation, 42 CFR § 413.89(e) (*Criteria for Allowable Bad Debt),* is available at ***http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr413_04.html*** on the Internet. Sections 308 and 310 of the PRM Manual (CMS Publication 15-1) are available at ***http://www.cms.hhs.gov/Manuals/PBM/list.asp*** on the CMS website.

Statement of Financial Policy

Bristol Hospital expects payment in full for all services rendered within 3 months of service date, unless other arrangements are made. All claims with verified insurance coverage and assigned benefits will be billed by the Hospital to the insurance company as a service to its patients. The patient is always ultimately responsible for payment of services received.

Bristol Hospital



Policy & Procedure

Title:	Financial Assistance	Effective Date:	10/01/2009
Dept:	Patient Financial Services	Review Dates:	10/01/2010
Policy No.	002	Revised Dates:	
		Page:	1 of 3

Financial Assistance

Policy:

Bristol Hospital is committed to providing financial assistance to the community by reducing fees to qualifying patients.

Definition:

The following definition is applicable to all sections of this Policy:

Patient Assets: All interests of the Obligor in property other than income that is readily convertible into cash including, but not limited to, bank accounts; trust accounts; tax refunds; investment accounts; stocks and bonds; bankruptcy, probate and insurance claims; and accounts receivable, but excluding any retirement plan such as a 401(k) plan, Keogh plan, and profit sharing plan, established and maintained to provide for retirement benefits through yearly tax deductible contributions to the plan. Also included for consideration are owned homes and vehicles (the primary residence and one car will be excluded).

GUIDELINES AND ALLOCATION PLAN

Reduction will be based on family income and size (see Addendum). 100% financial assistance will be provided to patients whose income is 100% (1x) of the Federal Poverty Guidelines (FPG) or lower. Patients above 100% of the FPG and up to 250% of the FPG are eligible for a sliding scale discount. In calculating family income, considerations will be given to patient assets, income and current indebtedness.

Family members consist of patient, spouse, biological children, adopted children, or other verifiable dependents. The Federal Income Tax Return will confirm dependent status for self-employed individuals. If the dependent's guarantors are divorced, a birth certificate may be used for confirmation of dependent status.

All applicants are required to secure benefits from any third party coverage plan and/or apply and receive determination for State assistance available before requesting a reduction. No applications will be accepted until the Hospital receives proof of benefits or lack thereof.

All applicants are required to complete the application process according to the Hospital policy. Eight (8) weeks of pay stubs, a single stub with year-to-date total, or a notarized statement of unemployment are required. Patients receiving Social Security Income will need to submit the letter they receive from Medicare stating their benefits or a full month's worth of bank statements. Each applicant completing the application process will receive a written letter of eligibility determination.

All outstanding patient balances that are 90 days or younger that are active on the receivable at the time of determination will be considered for reduction. Accounts previously placed in bad debt or that may have other income adjustments will not be considered for reduction. All reductions will be applied to balances after any third party activity has occurred (i.e., insurance payment or denial).

All patients with services other than outpatient mental health and other recurring services will be required to reapply for each new service episode. Approved reductions will be re-evaluated every six months for outpatient mental health patients and other recurring services. It is the patient's responsibility to inform Bristol Hospital of any changes, including coverage issues. If the level of assistance is changed, it will only apply to balances from the re-application period onward.

ADMINISTRATIVE RESPONSIBILITY

It is the responsibility of the Manager of Patient Financial Services to comply with the Hospital policy guideline governing the distribution of financial assistance reductions.

The Manager of Patient Financial Services is responsible for all application determination and allowance procedures.

Allowances will be administered via monthly log and will be submitted timely to the Director of Patient Financial Services and Revenue Cycle.

Reductions over $5,000 will require the approval of the Chief Financial Officer.

The Hospital will annually report the number of applicants for financial assistance, the number of approved applicants, and the total and average charges and costs of the amount of financial assistance provided to the Office of Health Care Access (OHCA).

The Director of Patient Financial Services and Revenue Cycle will review and approve any requested exceptions in the administration of changes in the reduction process in conjunction with the Chief Financial Officer.

The Hospital Controller, along with the Director of Reimbursement, is responsible for all calculations required by this policy including fee scales and financial assistance allocation, and the monitoring and quarterly written communication of compliance standards to OHCA. The hospital shall make available and prominently post in a place and manner allowing individual members of the public to easily obtain it, a one-page summary in English and Spanish describing hospital bed funds and how to apply for them. This summary is available and prominently posted in all patient registration areas (including the emergency room waiting room), the billing office and from any collection agents.

All Payor General Billing Policy

- All patients are charged for services received according to the approved charge master of the Hospital.
- All charges are entered by the servicing department according to the patient account number.
- All claims are produced by the in-house computer system on the designated uniform bill UB92.
- All claims are billed to the responsible party or third party payor based on current requirement and within three (3) days of in-house generation.
- All patients are billed for balances appropriate according to Bristol Hospital policy and contractual agreements.

BRISTOL HOSPITAL REDUCED FEE POLICY

STATEMENT OF POLICY

Bristol Hospital will administer reduced fees in the minimum amount of $500,000 per year to inpatients, ambulatory surgery patients, outpatient recurring services, single occurrence outpatient services with charges totaling $500.00 or greater and Counseling Center clients, in accordance with its policy for insured balances, or any uninsured balances. Effective October 1, 1996, there will be no $500.00 minimum required for uninsured patients.

GUIDELINES AND ALLOCATION PLAN

Reduction will be determined on a first come first serve basis. 100% financial assistance will be provided to patients whose income is 100% of the Federal Poverty Guidelines (FPG) or lower. Patients above 100% of the FPG and up to 250% of the FPG are eligible for a sliding scale discount. Exceptions will be considered based on individual circumstances and will require the review and approval of the Director of Patient Business Services.

Income will be evaluated on eight (8) consecutive weeks of gross earnings, verified by paycheck stubs, signed letter of income verification from the employer, official unemployment history report, notarized statements or federal income tax return if self-employed. Income will be calculated by totaling up the 8 consecutive weeks of gross earnings divide that number by 8, then multiply that number by 52 weeks. Income will be re-evaluated after four (4) weeks of any significant financial change for recurring services, as stated on the determination letter.

The family unit is defined as any single or married person eighteen years of age or older and spouse or live-in boyfriend/girlfriend and dependents or the parent/step parent or guardian of a patient under the age of eighteen, who resides in the same dwelling.

All applicants are required to secure benefits from any third party coverage plan and/or apply and receive determination for State assistance available before requesting a reduction. No applications will be accepted until the Hospital receives proof of benefits applied to each account balance.

All applicants are required to complete the application process according to Hospital policy. Each applicant completing the application process will receive a written letter of eligibility determination.

All appropriate account balances within the designated scope of services and within the applicant's guarantor account, at the time of determination will be considered for reduction. Accounts that may have other income adjustments will not be considered for reduction. All reductions will be applied to balances after insurance and all third-party-payor and/or administrators of other agencies have made appropriate payments and/or determinations.

Services included in this allocation plan are those designated in this statement of policy. All patients with services other than outpatient mental health and other recurring services will be required to reapply at each encounter. Approved reductions will be re-evaluated every six months for outpatient mental health patient and other recurring services. Any changes, including coverage issues, are the patient's responsibility. Any changes in past reductions will be calculated on balances owed at the time of re-application.

Referrals can be made by any Hospital employee who deals with patient financial matters. Patients will be referred directly to the Financial Assistance Department.

ADMINISTRATION AND RESPONSIBILITY

It is the responsibility of the Financial Counselor to comply with the Hospital policy guidelines governing the distribution of Reduced Fee reductions.

The Financial Counselor is responsible for all application determinations and allowance procedures.

Allowances will be administered via monthly log and will be submitted timely to the Accounts Receivables Department Supervisor.

The Financial Counselor is responsible for all the record keeping including a written log of all allowances and pertinent information for audit purposes. Record keeping will include a copy of each application and determination letter and proof of adjustment application.

The Director of Patient Business Services will review and approve any requested exceptions in the administration of changes in the reduction process.

The accounting department is responsible for all calculations required by this policy including fee scales, reduced fee allocation amounts and the designated detail of procedure for such, the publication of information regarding these calculations to the public, and the monitoring and quarterly written communication of compliance standards to the appropriate persons and/or Agencies.

FREE BED FUND APPLICATION PROCESS

PLEASE READ THIS CAREFULLY

Attached please find the Free Bed Fund application.

If you feel you may be eligible according to these guidelines, please bring in the following information, along with your completed application, to the Bristol Hospital Financial Assistance Department. This income verification applies to all family members residing at your legal address.

- Last Income Tax Return Filed
- Statement of wages from Unemployment Compensation showing date unemployment started, if applicable.
- Payroll stubs for the last eight- (8) consecutive weeks. If there is no income for the last eight – (8) weeks, a notarized letter stating that no income has been received in the last eight weeks.

This information is required to process your application. If you have any questions or concerns regarding this process, please contact our Financial Assistance representative at (860) 585-3534, or come in and we will be happy to assist you with this process. The Financial Assistance Department is open Monday through Friday 8:00 a.m. to 4:30 p.m. Thank you for your prompt attention to this matter.

Date App. Sent:_____

BRISTOL HOSPITAL, INCORPORATED
APPLICATION FOR FREE BED FUND

Date of Request:_____

Name: _____
Last First M.I.

Address: _____
Number and Street City State Zip

Social Security Number: _____Home Telephone:_____

Account #('s)_____

List of Household Members and Their Relationship:

Name	Relationship	Age

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can judge my eligibility for free bed funds. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature: _____

The Financial Assistant Department will respond to your request accordingly.
_____Approved: Reduction Rate: _____% of service not covered by insurance
_____Denied: _____

_____Coordinator, Financial Assistance Date_____

BRISTOL HOSPITAL, INC.
FREE BED FUND
ELIGIBILITY DETERMINATION

Date: _____

Applicant's Name: _____

Address: _____

Account Number(s): _____

Dear Client:

Your application for free bed funds has been processed. Your eligibility has been determined as follows:

Date Completed Application Received: _____

Date Application Processed: _____

_____Approved: Reduction at _____% of charges.

Patient Amount Due: _____

_____

_____Denied: Reason For Denial_____

_____

_____ Coordinator, Financial Assistance

_____ _____
Maria Simmone Director Revenue Cycle

Chief Financial Officer

Cindy Beliveau
Coordinator, Financial Assistance
860-585-3878

FREE BED FUNDS
COLLECTION POLICY AND PROCEDURE

PURPOSE: To process patient balances according to Section 19a-673 of the Ct. General Statues.

Patient accounts are considered **"uninsured"** as defined by the Ct. General Statues governing Free Care. The Guarantor will need to comply with the financial arrangements assigned by Bristol Hospital's Financial Assistance Department in order to be eligible for Free Bed Fund assistance.

The following sequence will apply:

1. A UB bill will be sent to the Guarantor at the time of billing and will include Bristol Hospital's Free Bed Information Form.

2. The Guarantor will continue to receive monthly statements (28 days apart) and follow regular collection policy and procedure until the Financial Department receives application from the guarantor. The Financial Assistance department will enter action code "LL" in the on line system to indicate the account is pending determination.

3. The Credit Department will bypass any further collection action on pending accounts and the account will remain in a "pending Free Bed" category until further notice.

4. If the account is approved for Free Bed Funds, the discounts and adjustments are entered on the log by the Financial Assistance Department and sent to the Pt. Receivable Manager for data input.

   If the account is denied free Bed Funds due to failure to meet Bristol Hospital's guidelines, the account will be considered an "Insured Patient" and the Credit Department will follow the appropriate procedures for Insured Patients including sending the final notice of "insured" status on the unpaid balance.

REDUCED FEES APPLICATION PROCESS

PLEASE READ THIS CAREFULLY

Attached please find the Reduced Fees application.

If you feel you may be eligible, please bring in the following information, along with your completed application, to the Bristol Hospital Financial Assistance Department. This income verification applies to all family members residing at your legal address.

- If Self Employed Last Income Tax Return Filed.
- Statement of wages from Unemployment Compensation showing date unemployment started, if applicable.
- Payroll stubs for the last eight- (8) consecutive weeks.
- If there is no income for the last eight – (8) weeks, a notarized letter stating that no income has been received in the last eight weeks is required.
- State of Ct determination letter for Medicaid Services.
- Current bank statement for Savings and Checking Account(s).
- If you receive Social Security Benefits please provide the current letter from Social Security or a most recent bank statement showing the direct deposit of the funds.
- If you receive a monthly pension check please provide proof either by providing a copy of the check or if direct deposited please provide a copy of the bank statement showing the deposit amount.
- If you have any stocks/bonds or investment accounts please provide current documentation including value.

This information is required to process your application. If you have any questions or concerns regarding this process, please contact our Financial Assistance representative at (860) 585-3534, or come in and we will be happy to assist you with this process. The Financial Assistance Department is open Monday through Friday 8:00 a.m. to 4:30 p.m. Thank you for your prompt attention to this matter.

Date App. Sent:_____

BRISTOL HOSPITAL, INCORPORATED
APPLICATION FOR REDUCED FEES

Date of Request:_____

Name: _____
Last First M.I.

Address: _____
Number and Street City State Zip

Social Security Number: _____Home Telephone:_____

Account #('s)_____

- Please list any property you may own this includes, homes, vehicles, recreational vehicles, etc**:**_____
  _____
- Please list any assets you may have this includes, stock or bonds, investment accounts, tax refunds, etc.

List of Household Members and Their Relationship, only children under 18 years of age will be considered:

Name	Relationship	Age

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can judge my eligibility for services on a reduced fee scale based on the established criteria on file. Further, I agree to make re-application based on the institutions policy. The hospital is required to re-evaluate my financial information every six months, consistent with hospital policy. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

I understand that should I be determined to be eligible for a reduced fee, I must comply with the payment schedule deemed appropriate for my financial circumstances.

Applicant's Signature: _____

The Financial Assistant Department will respond to your request accordingly.
_____Approved: Reduction Rate: _____% of service not covered by insurance
_____Denied: _____
_____,Coordinator, Financial Assistance Date_____

BRISTOL HOSPITAL, INC.
REDUCED FEE
ELIGIBILITY DETERMINATION

Date: _____

Applicant's Name: _____

Address: _____

Account Number(s): _____

Dear Client:

Your application for reduced fee has been processed. Your eligibility has been determined as follows:

Date Completed Application Received: _____

Date Application Processed: _____

_____**Approved:** Reduction Rate_____**%** of services not covered by insurance.

Your new balance is $_____

_____

_____

_____**Denied: Reason For Denial**_____

_____

_____ 860 585 3878
Coordinator, Financial Assistance

_____ _____
Maria Simmone Director Revenue Cycle Chief Financial Officer