	Connecticut Children's Medical Center - Policy and Procedure Manual		
Connecticut Children's MEDICAL CENTER	Fiscal	Date Effective:	November 01, 2007
	Patient Financial Assistance	Date of Origin:	March 01, 2002
	Approved By: Finance Administration, Corporate Compliance Committee	Date Approved:	November 01, 2007

I. Purpose

It is the purpose of this policy to describe the financial assistance programs and services at Connecticut Children's Medical Center.

II. Policy

It is the policy of Connecticut Children's Medical Center (Connecticut Children's) that Connecticut Children's will provide services at reduced or no cost to uninsured patients and others who meet Connecticut Children's Patient Financial Assistance (PFA) eligibility requirements. An uninsured patient is defined as a patient or guarantor whose income is at or below 250% of the federal poverty income guidelines, was denied Medicaid or other government coverage and has no coverage from other sources.

Patient Financial Assistance is not available to uninsured foreign nationals who are not Connecticut residents, except with the approval of the Chief Financial Officer through programs such as "Heal the Children."

III. Criteria

A. Scope

1. Public notices and written summaries about Connecticut Children's financial assistance program shall be available to patients and their families in English and in Spanish, as required by the State of Connecticut Public Act 03-266, An Act Concerning Hospital Billing Practices.

IV. Procedure

A. Patient Financial Assistance application process:

1. In order to be eligible for PFA, the "Patient Financial Application" form must be completed and supporting documentation provided, as applicable. Spanish versions of the form shall be made available, and translators shall be available as needed for completing the forms in other languages. If necessary, a Financial Counselor may assist the patient guarantor in completing the form.

B. Patient guarantor responsibilities:

1. PFA shall be considered only if the patient guarantor has exhausted all other avenues for obtaining funds for payment. Documentation supporting denials for Medicaid coverage, or proof of non-eligibility for Medicaid shall be required.
2. Re-application must be made for each date of service or once every 6 months, whichever is greater.

C. Connecticut Children's responsibilities:

1. Financial Counselors shall review the PFA application and supporting documentation, as applicable. Patient account information shall be updated to

reflect that the patient account(s) are "pending" the PFA decision, so routine collection procedures are not initiated. The Financial Counselor processes the application using the Connecticut Children's PFA Determination methodology. If the patient account qualifies for PFA, the application package shall be forwarded to the Healthcare Access Manager for review and approval. If approved:

a) The Financial Counselor sends a PFA award letter to the patient guarantor.

b) A copy of the Patient Financial Assistance Worksheet is forwarded to Patient Accounts, so they can "write off" the specific amount awarded from the appropriate account(s).

2. If the patient account does not qualify for PFA, the following occurs:

a) The Financial Counselor sends a PFA denial letter to the patient guarantor.

b) A copy of the Patient Financial Assistance Worksheet is forwarded to Patient Accounts and routine collection procedures proceed.

3. If a patient requests financial assistance after the account has been sent to a collection agency, a PFA application shall be sent to the patient and the account withdrawn from the agency.

V. References

VI. Related Documents

Credits & Collections

PFA Application → g:\CCMCDOC\forms\PFA\PFA Application.doc

PFA Determination Worksheet → g:\CCMCDOC\forms\PFA\PFA Determination Worksheet.doc

PFA Award Letter → g:\CCMCDOC\forms\PFA\PFA Award Letter.doc

PFA Denial Letter → g:\CCMCDOC\forms\PFA\PFA Denial Letter.doc

Hartford Health Care Corporation and Connecticut Children's Medical Center	4.4 Patient Credit and Collection Policy & Procedures		
Patient Financial Services	Section 4: Departmental Policies		1
Approved by: **Niobis Queiro, HHCC Revenue Cycle Director**	Date Issued: 11/24/03	Last Reviewed/Revised Date: 08/02/10	

Purpose: The primary responsibility of Hartford Health Care Corporation and Connecticut Children's Medical Center is to provide the highest quality of medical care to its patients at the lowest cost. In order to meet these requirements, an efficient and equitable system must be established that will maximize the collection of patient accounts receivable balances in order to provide the cash flow required to operate our institutions effectively.

Scope: All PFS Admissions, Billing and Collection areas.

Policy: In accordance with the above, the following Credit and Collection Policy is hereby established for The Hartford Health Care Corporation and Connecticut Children's Medical Center. Detailed procedures and exceptions to this policy will be included in a Credit and Collection Manual.

The Following are Procedures included in this Policy:

I. Admissions Procedures
II. Billing Procedures
III. Collections Procedures

Definitions: Throughout this policy reference to Patient Financial Services will constitute reference to collection processes for Hartford Health Care Corporation and Connecticut Children's Medical Center.

In this credit policy, the term "Patient" refers to the party responsible for the payment of the hospital bill. Further, the expression, "patient portion" is to include all non-covered third party charges, such as deductibles, co-insurance, outpatient pharmacy charges, etc.

Patient classifications are defined as follows:

A. Inpatient: Patients requiring inpatient services as deemed necessary by a physician.
B. Emergency Patient: Patient treated in the emergency department for a condition that requires immediate attention.
C. Private Referred: A Patient referred to one or more of the hospital's ancillary service areas by either the hospital's medical staff or other private physician.
D. Clinic Patient: A patient who is registered in one of the hospital's outpatient areas and is treated in one or more of the specialty clinics.

Sources of Payment	Procedure
A. Patient	The primary responsibility for settlement of the account will rest with the patient. All patients, capable of doing so, will be required to sign an assignment and authorization form (attached) for guarantee of payment prior to admission or receipt of services. In any controversy, default, or misrepresentation the hospital will contact the patient for payment of the bill.
B. Third Party Coverage	Patient Financial Services will extend credit on third party benefits assigned to the hospital upon proper validation of coverage. Principal third party payers recognized in the hospital system are as follows: • Blue Cross • Medicare/Medicaid • Managed Care Companies (contracts on file with Contract Liaison) • Commercial Insurance Companies, including medical benefits on auto insurance policies (upon assignment of benefits to the Hospital) • HMOs (upon assignment of benefits to the Hospital) • Worker Compensation (upon confirmation / validation of claim) Patient Financial Services will cooperate with all third party payers to the fullest extent in order to facilitate the collection of patient bills.
C. Patient Balance (Self-Pay accounts and/or residual balances after third party payments)	Acceptable forms of payment are: 1. Cash or money orders. 2. Personal or travelers checks with proof of identity. 3. Credit cards – MasterCard, Visa, American Express and Discover Card.

D. Payment of Uninsured Hospital Charges	Patient Financial Services will require, or request payment for the difference between the estimated patient bill and the total available third party coverage. For any non-emergency services, the Hospital will attempt to obtain payment from the patient for the patient portion of the bill. after estimated coverage. All past due accounts would also be required to be paid prior to the current non-emergent admission. The following procedures will require payment in full prior to services being rendered. • Pregnancy Termination • Paternity Testing • Dentures • Cosmetic Surgery • Foreign Nationals
E. Charity Care/ Financial Assistance *Does not apply to CCMC.	Hartford Health Care Corporation recognizes its responsibility to those patients unable to pay for services rendered. 1. Various Hospital Free Bed Funds are available to meet this recognized need. They are available as a last resort after all other available third party resources have been exhausted. Patients are encouraged to apply for Title XIX prior to consideration for Free Bed Funds. 2. Charity Care is also available to patients on an as needed basis. A notice of Charity Care availability is included in the Patient Statement. Patients must submit all necessary information and must meet the criteria as outline in the Financial Assistance Policy and Procedure. Exceptions may be made with the approval of PFS Director. 3. Management approval of these funds are required as follows: • Under $10.000 – Self Pay Supervisor • $10,000 to $49,999– Self Pay Manager • $50,000 to $150.000– PA Director • Over $150,000 – Revenue Cycle Director • Approval/denial letters are mailed to patients

	upon a decision is made following the review of the submitted information.
E. Patient Inquires	Patient inquiries related to the Credit and Collection Policies of the Facilities, must be addressed by only those individuals designated within the Patient Financial Services Department.

PROCEDURES:

I. Admissions Procedures:

Admission Type	Procedure
A. Pre-Admissions	Facilities will Pre-Admit patients whenever possible. The payment sources chosen for settlement of a patient's account will be verified prior to admission (i.e., verifying coverage thru available on-line products, confirmation directly with the payer, employer, or validation (photocopy) of appropriate insurance data). In addition, the provisions of Section III-D above must be satisfied.
B. Elective Admissions	Elective admission referrals must be received in the Pre-Admitting office, at least one day after booking the reservation in the Admitting Office or by Service Access. All elective admissions are subject to the payment of uninsured Hospital charges as established in Section III-D above.
C. Emergency Admission	Facilities will admit all emergency cases irrespective of the financial condition of the patient. The admitting physician must certify as to the emergency status when requesting the admission.

II. Billing Procedures:

All patient/guarantors will receive a series of statements when there is no third party coverage, or all third party coverage has been satisfied (paid or rejected).

The exceptions are:

- Medicare accounts will not receive correspondence until Medicare has paid and/or rejected the claim.

- Medicaid accounts and accounts in which the hospital has a contractual obligation not to bill until the claim has been paid and/or rejected.

A. Bills are produced or available for production five days after discharge. The billing process will begin as soon as the bills are available. Detail bills are available upon request.

B. Accounts pending coverage determination will be treated as if no coverage is available and treated as a self-pay account.

C. Rejected third party claims or those with a residual balance will be changed to patient pay and dunned for the amount due.

D. Once self-pay status is determined, financial counselors are available to assist with Title XIX applications.

III. Collection Procedures:

Revenue Cycle policy dictates that all bills are due and payable, in full, within thirty days of the time of billing.

If the patient is unable to commit to the terms of a suitable payment plan, he or she will be screened in accordance with the Hartford Hospital Financial Assistance Policy.

In the event that the patient cannot obtain the necessary funding and/or use a credit card, payment arrangements would be made as a last resort under the following terms:

Monthly payments are to be established and paid each and every month. Guidelines are listed below:

Self-Pay Balance	Payment Plan Guidelines
Under $100	Payment in full
$100 to $349	3-month payment plan: one-third of the balance to be paid each month
$350 to $1,199	6-month payment plan: one-sixth of the balance to be paid each month
$1,200 to $2,499	12-month payment plan: one-twelfth of the balance to be paid each month
$2,500 and above	Minimum $200 to be paid each month.

Patient statements are system generated according to the schedules outlined in sections A B and C. Accounts will be transferred to the appropriate financial class whenever payments or rejections are received from Third Party Payers.

A. **Self Pay-Financial Class P – A/R & Daily Outpatient Accounts**
Upon discharge, final bills are processed and statements are generated based on the following cycle:

In the event of returned mail, the statement cycle below will be interrupted and the account will be transferred to the appropriate collection agency for proper follow-up.

Days after Billing (AR/Reg Date (OP)	Procedure
10	First statement with message
35	Second statement with message
57	Third statement produced
79	Fourth Statement
101	Fifth Statement
122	Reviewed for transfer to Collection Agency. Split by Hospital. • **Hartford Hospital** A-G Century Collections (FC 3) H-I Connecticut Credit (FC 1) J-R Nair & Levin (FC 5) S-Z Connecticut Credit (FC 1) • **MidState Medical Center** A – L Century (FC 3) M – Z Nair & Levin (FC 5) • **CCMC** A – L Century (FC 3) M – Z Nair & Levin (FC 5) o Daily Outpatient – automated process. o A/R & Unitized – manual process* *(Day of transfer may vary for Unitized and may be greater than 122 days)

In addition to the above schedule, telephone contact may be initiated.

B. **Self Pay – Residual- Financial Class Q – A/R & Daily Outpatient Accounts**
Residual balances after third party payment/rejection will proceed through the appropriate statements, messages, letters and phone calls as follows:

The day after all third parties are satisfied (paid or rejected) a statement showing the charges, credits and payments applicable thereto and the resulting self-pay balance will be produced and mailed to the patient.

In the event of returned mail, the statement cycle below will be interrupted and the account will be transferred to the appropriate collection agency for proper follow-up.

Days after FC Change	Procedure
1	First statement with message
21	Second statement with message
42	Third statement produced
64	Fourth statement produced
86	Fifth Statement produced.
108	Sixth statement produced.
122	Reviewed for transfer to Collection Agency. Split by Hospitals • **Hartford Hospital** A-G Century Collections (FC 3) H-I Connecticut Credit (FC 1) J-R Nair & Levin (FC 5) S-Z Connecticut Credit (FC 1) • **MidState Medical Center** A – L Century (FC 3) M – Z Nair & Levin (FC 5) • **CCMC** A – L Century (FC 3) M – Z Nair & Levin (FC 5) o Daily Outpatient – automated process. o A/R & Unitized – manual process.* *(Day of transfer may vary for Unitized and may be greater than 122 days)

*System automation exists to move daily Outpatient accounts from In house Self Pay Team to the Outsourcing agency and from the Outsourcing agency to the Collection agency as follows:

1. FC P and Q accounts are worked in house for 60 days.
2. After 60 days of no resolution, the accounts are then transferred to the Outsourcing agency (currently split between Nair and CT Credit).

- 60 days from last PT detail bill for FC P accounts.
- 60 days from last financial class change for FC Q accounts.

3. After 60 days with the Outsourcing agency, the account is transferred to a Collection agency (see Procedure on Section A and B.) as follows:
   - If a payment is made and there is a balance after payment, the system will count 40 days since the last payment and then transfer the account to the Collection agency.
   - If no payment has been made, the system will count 121 days:
     - From Registration date for FC P accounts.
     - From last Financial Class change for FC Q accounts.

C. Self Pay-Unitized Accounts:

1. Financial Class P – Account Level
   Statements are produced at the on the 9th day of every month
2. Financial Class Q – Account Level
   - Statements are produced one day after financial class changed to 'Q' at the account level.
   - Statements are produced on the 10th day of every month after the initial financial class 'Q' statement.
3. Financial Class Q - Unit Level
   Statements are produced on the 22nd day of every month

Accounts will advance through the self-pay cycle outlined above.

In all cases, the cycle detailed for all accounts can be interrupted by one or more of the following occurrences:

a. Receipt and verification of third party coverage.
b. Payment arrangements are agreed to and followed by the patient/guarantor.
c. Evidence that the account is uncollectible or other legal consideration results in an expedited referral to an agency or attorney.
d. Patient notifies us of inability to pay and applies for financial assistance.
e. Follow up to complaints or appeals is required

D. Medicaid

During the Pre-Admission and/or hospitalization, Patient Accounts personnel and/or Service Access personnel will explain the Medicaid application procedure, aid the patient in completing the application and provide assistance to the patient in obtaining eligibility.

VI. General Policies:

A. General policies have been established to control the activities in the collection cycle.

B. A timely filing period of 10 months from the last date of activity on the account (insurance denial/collection effort) will be followed for the billing to Patients.

- Once this limit is met, the patient balance will be written-off to service code 906347 "Special Purpose, Not RR". Or 906289 "special Purpose, Old RR"
- Any exceptions to this policy must be approved by the Hospital's CFO.

C. Patient Accounts will not Balance bill the parent of a baby born within our facilities who expires within the first 24 hours after delivery.

- The Insurance is to be billed.
- Co-Pay's and/or Deductible's will be written off to Charity Care by the Self Pay Team and deemed a "Hardship" presumptive eligibility situation for purposes of the Hospital's Charity Program.

D. Patient Account Management and the Vice Presidents of Finance will review monthly write offs. The purpose of this review will be to identify the sources of bad debts and administrative write offs to propose solutions.

Author: PFS/zlb

Reviewed By: Niobis Queiro, HHCC Revenue Cycle Director
Shelly McCafferty, Patient Accounts System Director
Robert Leake, CCMC Director of Revenue and Reimbursement
Ralph Becker, MSMC VP of Finance
Gary Bergenty, Self Pay Manager
Kathy Bartucca, Self Pay Supervisor
Lorraine Gamble, Customer Service Manager
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Zelma Berube, Revenue Cycle Integrity Manager

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Last Reviewed/Revised Date: 8/02/10

Connecticut Children's Medical Center
Financial Assistance Application

√ This is for hospital bills only. This will <u>not</u> help with doctor, anesthesia, or lab bills.

√ This will determine how much, if not all, of your expenses the hospital will be able to assist you and your family with.

Patient's name: _____ Date Of Birth _____
Address: _____
City: _____ Zipcode: _____

Home phone#: _____ Work phone #: _____

Is the patient a U.S. Citizen? ❑Yes ❑ No

Is the patient a U.S. Resident? ❑Yes ❑ No

Please tell us about your family (the people who live in your home):

Name(s)	**Sex**	**Date of Birth**
Mother or Legal Guardian:	M F	
Father or Legal Guardian:	M F	
Child:	M F	
Child:	M F	
Child:	M F	
Child:	M F	

Connecticut Children's Medical Center
Financial Assistance Application

Please tell us about your family's income:

Income	Mother	Father	Total
Monthly Pay	$	$	$
Unemployment			
Social Security/Military			
Support/Alimony			
State Welfare			
Other			

If you have no income, please tell us how us how your family meets their needs:

_____

_____

_____

_____

_____

Bank Accounts	Mother	Father	Total
Checking	$	$	$
Savings			
Other Account(s)			

Connecticut Children's Medical Center
Financial Assistance Application

Please tell us about your family's expenses:

Bills	Monthly Payment
Mortgage/Rent	
Credit Cards: Visa, Mater Card, American Express, Other	
Utilities: electricity, gas/oil, water, cable, telephone, other	
Child Support	
Alimony	
Medical Bills	
Child Care	

You will need to provide the following information:

Please include **ONE** of the following -

❑ A copy of your last 4 pay checks, a letter from your employer with the amount of hours that you work and your pay rate, or a copy of your original unemployment check.

❑ A copy of your last Federal Income Tax return

Please include **ALL** of the following -

❑ Copies of your last 3 rent or mortgage payments

❑ A copy of your I.D. (license, passport, visa)

❑ A copy of your last 3 bank statements

❑ A copy of your last 3 payments of your bills (phone/lights/cable/heat/electricity)

❑ A copy of your outstanding medical bills

Connecticut Children's Medical Center
Financial Assistance Application

Please read and sign below:

I am asking for financial help from Connecticut Children's Medical Center. All of the information provided on this application is true and I understand that it will be verified. I agree to provide any additional financial information that is requested by Connecticut Children's Medical Center.

Parent /Guardian Signature:_____ Date: _____

Please mail this completed form and your required documentation to:

Barbara Farrell, Financial Counselor
Connecticut Children's Medical Center, Suite 2D
282 Washington Street
Hartford, CT 06106.

Questions? Please call 860-545-8086 Monday through Friday 8:00 AM – 4:00PM

√ Please be sure to include all requested information to ensure timely determination.

Connecticut Children's Medical Center
Patient Financial Assistance Determination Worksheet

Patient Name	
Medical Record Number	
Family Size	
Gross Family income	

Federal Poverty Guidelines 2009

Family size	FPIG	200%	250%	275%	300%
1	10,830	21,660	27,075	29,783	32,490
2	14,570	29,140	36,425	40,068	43,710
3	18,310	36,620	45,775	50,353	54,930
4	22,050	44,100	55,125	60,638	66,150
5	25,790	51,580	64,475	70,923	77,370
6	29,530	59,060	73,825	81,208	88,590
7	33,270	66,540	83,175	91,493	99,810
8	37,010	74,020	92,525	101,778	111,030

Percentage of account balances eligible for PFA

250 % or less = 100%

Over 250% but less or equal to 300% = 50%

Over 300% = 30% (SPD)

Medical Record	Account Number	Date of service	Account Balance	Amount eligible for PFA

Approved **Denied**

Application prepared by: _____ Date_____

Comments:_____
_____
_____
_____

Manager's Signature_____ **Date:** _____

Connecticut Children's Medical Center
Patient Financial Assistance

«GNAME»
«ADDRESS»
«CITY», «STATE» «ZIP»

Dear «GNAME»:

Thank you for completing a Financial Assistance Application. Based on your application, you qualify for financial help from Connecticut Children's Medical Center!

You qualify for <<percent>>.

Account Number	Date of Service	Previous Balance	Financial Assistance	Current Balance
		$	%	**$0.00**
			Total Amount Due:	**$0.00**

Please pay the total amount due upon receiving this letter. If you cannot pay the amount in full, please contact the Patient Accounts Department at 1-888-690-2262 (toll free) or 860-696-6020 to arrange a payment plan.

If you have any questions or concerns please contact the Financial Counselor's office at 860-545-8086 Monday through Friday 8AM-4PM.

Barbara J. Farrell
Financial Counselor
Connecticut Children's Medical Center
282 Washington Street, Suite 2D
Hartford, CT 06106
860-545-8086

Connecticut Children's Medical Center
Patient Financial Assistance

<<NAME>>
<<Address>>
<<City, State Zip>>

Dear<<NAME>>,

Thank you for completing a Financial Assistance Application. Based on your application, you **do not** qualify for financial help from Connecticut Children's Medical Center.

<<REASON>>

You owe the following amount(s):

Account Number	Date of Service	Account Balance
Total Amount Due :		

Please pay the total amount due upon receiving this letter. If you cannot pay the amount in full, please contact the Patient Accounts Department at 1-888-690-2262 (toll free) or 860-696-6020 to arrange a payment plan.

If you have any questions or concerns please contact the Financial Counselor's office at 860-545-8086 Monday through Friday 8AM-4PM.

Thank You,

Barbara J. Farrell
Financial Counselor
Connecticut Children's Medical Center
282 Washington Street, Suite 2D
Hartford, CT 06106
860-545-8086