Waterbury Hospital
CREDIT & COLLECTION MANUAL

CHARITY CARE

CATEGORY: Credit & Collection	**POLICY: Charity Care**
	ORIGINATED: 12/5/97
REVIEWED: 6/10	**REVISED: 07/03, 01/07, 12/07,12/09**
RETIRED:	**Comment:**

SCOPE: Determination of when charity care is appropriate.
PURPOSE: To make provisions for situations in which charity care is appropriate based on aggregate balance and Encounter review.

POLICY: It is the policy of Waterbury Hospital to appropriately offer charity care in situations where balances are uncollectible and criteria meets established guidelines.

PURPOSE: To provide a mechanism to identify patients/encounters that are uncollectible due to specific reasons:

- No assets
- Deceased, no estate
- Homeless, no information
- Patient has recently been granted Title XIX

In addition, charity cases do not need to be presented to the Patient Assistance Committee:

- Balances in aggregate totaling <$1000 – write off to Charity Care
- Balances in aggregate totaling >$1000 - write off to appropriate Free Bed Fund

PROCEDURE:
When faced with one of the above situations, the Patient Financial Services Staff will do the following:

- Prepare an allowance sheet with the appropriate encounter numbers, documentation and summary bill.
- When submitting for a deceased patient, obtain a copy of the death certificate and/or verification from an authorized person i.e. relative, conservator, or caregiver. Estates must be verified by a phone call to the Probate Court of the city/town of residence. Some of the local probate numbers are: Waterbury 755-1127, Naugatuck 729-4571, and Southbury 262-0641.
- Self Pay outsourcing agency will send out the financial application.
- When these forms are received back, the customer service rep will review the outsourced encounters along with any outstanding encounters to determine if patient assistance should be pursued.
- On a weekly basis, the supervisor, Customer Service, will review all Encounters submitted for charity care.
- If the Encounter falls into a category for one of the free bed funds, then the

balance will be written off to that fund using the appropriate procedure code and recorded as a utilization of that free bed fund for accounting purposes.

Approved encounters for charity care will be written off to the Permanent Bed Fund and logged as charity care.

Denied encounters will be referred back to the person who submitted them for further review or follow-up if it is determined that there is a source of payment available.

Differences between Charity Care and Bad Debts:

Examples of charity care recipients

- Patients that are over income for assistance but are in financial hardship [working poor]
- Uninsured persons who are impoverished by daily expenses
- Patients who are unable to pay for services rendered and show true hardship

Bad Debts

- Patients who have the ability to pay but choose not to pay
- Patients who do not cooperate with the hospital during patient interviews i.e. providing needed information to complete assistance applications.
- Patients who do not follow through with assistance applications
- Patients who willfully give bad demographic information
- Encounters that are not resolved via collection efforts and there is no response from the patient or interest to resolve balances due.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

DMHAS INPATIENT GRANT

CATEGORY: Credit and Collection	**POLICY: DMHAS Inpatient Grant**
	ORIGINATED: 4/1/02
REVIEWED: 10/07,06/10	**REVISED: 01/07, 12/07,06/10**
RETIRED:	**Comment:**

SCOPE: Funding
PURPOSE: To grant DMHAS funding as applicable.

POLICY: It is the policy of Waterbury Hospital Health Center to follow the guidelines of the Department of Mental Health and Addiction Services [DMHAS] as it pertains to the granting of funds for inpatient care.

PROCEDURE:

- The DMHAS grant covers inpatient psychiatric care for patients who are NOT granted Title XIX or SAGA retroactive to July 1, 2001. The grant is considered the payer of "last resort".
- The following rules will apply to Patient Financial Services:
- Encounters that are accepted by R&B Medicaid Services and are subsequently closed, will have the following codes:
  - **DMHAS** health plan [Encounter will remain in SP financial class]
  - Statement suppression for DMHAS GRANT
  - Comment will also be placed on the Encounter.
- If Title XIX or SAGA [Value Options] denies coverage, the Encounter will also be eligible for grant funding.

Encounters that are deemed to be eligible for grant funding will have the following two aliases posted:

- **2301 - DMHAS IP GRANT PER-DIEM**
  The per-diem is currently $550 per day. Compute using total length of stay.
- **2300 - DMHAS IP GRANT ALLOWANCE**
  Subtract the per-diem total from the total revenue to compute the allowance.

Behavioral Health will monitor DMHAS grant funding.

Waterbury Hospital
Patient Access/ Financial Services
FINANCIAL ASSISTANCE APPLICATION FORM 2010

CASE # _____

DATE _____ Account #_____

I. PATIENT DATA – [If patient is a minor, [under 18] mother, father and/or guardian information must be completed]

Name _____ date of birth _____

Address _____

zip code _____
Phone number _____social security # _____

Mother's information
Name _____social security # _____
Date of birth _____ phone number _____

Address _____

zip code _____

Father's information
Name _____social security # _____
Date of birth _____ phone number _____

Address _____

zip code _____

Guardian's information
Name _____social security # _____
Date of birth _____ phone number _____

Address _____

zip code _____

CHURCH AFFILIATION:_____

Waterbury Hospital
Patient Access/ Financial Services
FINANCIAL ASSISTANCE APPLICATION FORM 2010

II. HEALTH INSURANCE [ ] YES [ ] NO

Insurance _____ **policy #** _____
Insurance _____ **policy #** _____

IF NO HEALTH INSURANCE, PLEASE READ THE INFORMATION ON THE LAST PAGE OF THIS APPLICATION.*

III. DEPENDENTS [not working and/or live in household, including spouse]

Name	Age	Birth Date	SSN #

Total number of dependents living in household _____

IV. THE FOLLOWING INFORMATION IS RELATED TO THE INDIVIDUAL RESPONSIBLE FOR PAYMENT:
Patient _____ **Responsible Party [give name]**_____
Employer name _____ phone #_____

Address

_____

Dates of employment: from _____ to _____

Gross weekly income _____ net weekly income _____

Gross income from income tax return_____year_____

Waterbury Hospital
Patient Access/ Financial Services
FINANCIAL ASSISTANCE APPLICATION FORM 2010

INCOME FROM OTHER SOURCES: **spouse ___dependent___ other___**
Employer name_____phone #_____
Address

_____

Dates of employment: from _____to _____
Gross weekly income _____net weekly income _____
MISCELLANEOUS INCOME

Source of Income	**Amount of Income**
Rent	
Pensions	
Social Security [SSN]	
Veterans' Security	
Workman's compensation	
Unemployment compensation	
Other :	
Other:	

Total from All Income Sources **$** _____

_____

PERSONAL / CAPITAL ASSETS

Personal Asset	Amount of asset	Capital Asset	Purchase Date	Price
Checking accounts		Real Estate [own home]		
Savings accounts		Automobile		
Life Insurance [cash surrender value]		Other:		
Securities and bonds		Other:		
Other:				
Other:				
Total personal		**Total Capital**		
Income Tax Refund (s)	Federal $ State $			

V. CURRENT DEBTS

Type of Debt	To Whom Paid	Monthly Payment	Balance
Mortgage			
Rent			
Gas			
Electric			
Phone			
Oil			
Income taxes due	IRS		
Finance Companies			
Credit Unions			
Life Insurance			
Homeowner/Rental Insurance			
Car Insurance			
Property Tax			
Other			
Other			

CHARGE ACCOUNTS

Credit card/Store	Monthly Payment	Balance

OTHER MEDICAL BILLS

Hospital/Doctor etc.	Monthly Payment	Balance

Total outstanding debts $ _____

IMPORTANT: SIGNATURE IS REQUIRED ON NEXT PAGE FOR VERIFICATION OF INFORMATION. UNSIGNED APPLICATIONS WILL BE RETURNED and/or DENIED, IF SIGNATURE NOT OBTAINED.

Waterbury Hospital
Patient Access/ Financial Services
FINANCIAL ASSISTANCE APPLICATION FORM 2010

VI. CERTIFICATION

I certify under the penalty of perjury that the information I have given is correct, true and complete. I also give permission for verification of all facts relating to my eligibility.

ACKNOWLEDGEMENT

Patient or guarantor signature _____

Witnessed by _____**date** _____

Address of above

_____

City, town _____State _____

******NOTE**** IF PATIENT IS CLAIMING NO INCOME, A NOTARIZED STATEMENT MUST BE PROVIDED FROM THE PERSON THAT IS SUPPORTING THE PATIENT FINANCIALLY**.

Please mail this application and the required information off the checklist to the address listed below.

WATERBURY HOSPITAL HEALTH CENTER
P.O. BOX 1590
WATERBURY, CT 06721

ATTN: PATIENT FINANCIAL SERVICES

Glossary of Terms Utilized in Financial Assistance Determinations

Definitions

There is no universal administrative definition of ''family,'' ''family unit,'' or ''household'' that is valid for all programs that use the poverty guidelines. Federal programs in some cases use administrative definitions that differ somewhat from the statistical definitions given below; the Federal office which administers a program has the responsibility for making decisions about its administrative definitions. Similarly, non-Federal organizations which use the poverty guidelines in non-Federally-funded activities may use administrative definitions that differ from the statistical definitions given below. In either case, to find out the precise definitions used by a particular program, please consult the office or organization administering the program in question.

The following statistical definitions (derived for the most part from language used in U.S. Bureau of the Census, Current Population Reports, Series P60–185 and earlier reports in the same series) are made available for illustrative purposes only; in other words, these statistical definitions are not binding for administrative purposes.

Family. A family is a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family. For instance, if an older married couple, their daughter and her husband and two children, and the older couple's nephew all lived in the same house or apartment, they would all be considered members of a single family.

Unrelated individual. An unrelated individual is a person (other than an inmate of an institution) who is not living with any relatives. An unrelated individual may be the only person living in a house or apartment, or may be living in a house or apartment (or in group quarters such as a rooming house) in which one or more persons also live who are not related to the individual in question by birth, marriage, or adoption. Examples of unrelated individuals residing with others include a lodger, a foster child, a ward, or an employee.

Household. As defined by the Census Bureau for statistical purposes, a household consists of all the persons who occupy a housing unit (house or apartment), whether they are related to each other or not. If a family and an unrelated individual, or two unrelated individuals, are living in the same housing unit, they would constitute two family units (see next item), but only one household. Some programs, such as the Food Stamp Program and the Low-Income Home Energy Assistance Program, employ administrative variations of the "household" concept in determining income eligibility. A number of other programs use administrative variations of the "family" concept in determining income eligibility. Depending on the precise program definition used, programs using a "family" concept would generally apply the poverty guidelines separately to each family and/or unrelated individual within a household if the household includes more than one family and/or unrelated individual.

Family Unit. "Family unit" is not an official U.S. Census Bureau term, although it has been used in the poverty guidelines Federal Register notice since 1978. As used here, either an unrelated individual or a family (as defined above) constitutes a family unit. In other words, a family unit of size one is an unrelated individual, while a family unit of two/three/etc. is the same as a family of two/ three/etc.

Note that this notice no longer provides a definition of "income." This is for two reasons. First, there is no universal administrative definition of "income" that is valid for all programs that use the poverty guidelines. Second, in the past there has been confusion regarding important differences between the statistical definition of income and various administrative definitions of "income" or "countable income."

The precise definition of "income" for a particular program is very sensitive to the specific needs and purposes of that program. To determine, for example, whether or not taxes, college scholarships, or other particular types of income should be counted as "income" in determining eligibility for a specific program, one must consult the office or organization administering the program in question; that office or organization has the responsibility for making decisions about the definition of "income" used by the program (to the extent that the definition is not already contained in legislation or regulations).

Dated: February 11, 2004.**Tommy G. Thompson,** *Secretary of Health and Human Services.* [FR Doc. 04–3329 Filed 2–12–04; 8:45 am] **BILLING CODE 4154–05–P**

U.S. Census Bureau

Family
A group of two or more people who reside together and who are related by birth, marriage, or adoption.

Family household (Family)
A family includes a householder and one or more people living in the same household who are related to the householder by birth, marriage, or adoption. All people in a household who are related to the householder are regarded as members of his or her family. A family household may contain people not related to the householder, but those people are not included as part of the householder's family in census tabulations. Thus, the number of family households is equal to the number of families, but family households may include more members than do families. A household can contain only one family for purposes of census tabulations. Not all households contain families since a household may comprise a group of unrelated people or one person living alone.
Source:

Unrelated individual
Person, sharing a housing unit, who is not related to the householder by birth, marriage or adoption. Includes foster children.

Income
"Total income" is the sum of the amounts reported separately for wages, salary, commissions, bonuses, or tips; self-employment income from own nonfarm or farm businesses, including proprietorships and partnerships; interest, dividends, net rental income, royalty income, or income from estates and trusts; Social Security or Railroad Retirement income; Supplemental Security Income (SSI); any public assistance or welfare payments from the state or local welfare office; retirement, survivor, or disability pensions; and any other sources of income received regularly such as Veterans' (VA) payments, unemployment compensation, child support, or alimony.

Waterbury Hospital Patient Access / Financial Services

CHECKLIST FOR FINANCIAL ASSISTANCE

_____ Proof of Residence (rent receipt, mortgate or letter from landlord.

_____ Proof of Debt (ALL BILLS OWED)

_____ Last 13 weeks wage stubs, letter from employer, or unemployment benefit letter

_____ Copy of SS/Pension/SSI or other benefit check or letter from agency

_____ Copy of child support check.

_____ Most current Income Tax statement

_____ Proof of assets (stocks, bonds, IRAs, CDs etc.)

_____ Complete bank account statement, checking and/or savings passbook (LAST 3 MONTHS)

_____ Life insurance policies

_____ Car registration

_____ Copy of Title XIX/Saga referral (W-1 form)

_____ Alien registration card or other proof of alien status

_____ Other_____

_____ Other _____

_____ Other _____

Waterbury Hospital
CREDIT & COLLECTION MANUAL

FREE CARE PATIENT INFORMATION

CATEGORY: Credit & Collection	**POLICY: Free Care Patient Information**
	ORIGINATED: 10/03
REVIEWED: 06/10	REVISED:01/07, 01/08, 12/09
RETIRED: Free Care Signage, replaced with Free Care Patient Information	Comment:

POLICY: It is the policy of Waterbury Hospital to provide patients with information relating to financial counseling services.

The following signs are posted at registration points of service:

ARE YOU HAVING PROBLEMS PAYING YOUR HOSPITAL BILLS?

If you are coping with a personal financial hardship, and are facing significant debts owed to Waterbury Hospital, Waterbury Hospital offers "free bed funds" to cover the cost (partially or fully) for inpatient, outpatient and emergency services rendered at the Hospital for qualifying patients.

To obtain further information, including an application, please contact our customer service representatives as follows:

- By phone at 203-573-7116, Monday through Friday, 8:30 a.m. to 3:30 p.m.
- By appointment or walk-in in the Patient Financial Services office (ground floor adjacent to the Main Lobby) Monday through Friday, 8 a.m. to 4:30 p.m.

ESTA USTED TENIENDO PROBLEMAS PAGANDO LOS BILES DEL HOSPITAL?

Si usted está pasando por un problema financiero o está usted en deuda con el Hospital de Waterbury, ahora el Hospital el ofrece un programa llamado "Fondo de Cama Gratis" para cubrir el gasto parcial o completo a los pacientes que son internados, dado de alta o en emergencia que visitan el Hospital. Este programa solamente es para esas personas que califican.

Para obtener más información, incluyendo una aplicación, por favor comuníquese con nuestra oficina de servicios al paciente en el horario indicado a continuación:

POR TELEFONO:
***203-573-7116, de lunes a viernes,* 8:30 a.m. to 3:30 p.m.**

CON CITA O SIN CITA:

Horario de la oficina: lunes a viernes, 8 a.m. a 4:30 p.m.

LAS OFICINAS DE ASISTENCIA AL PACIENTE ESTAN LOCALIZADAS EN LA PLANTA BAJA AL CRUZAR LA SALA DE ESPERA.

All statements sent from Waterbury Hospital will have the following information printed on the back of each statement:

ARE YOU HAVING PROBLEMS PAYING YOUR HOSPITAL BILLS?

Waterbury Hospital offers "free bed funds" to cover the cost (partially or fully) for inpatient, outpatient and emergency services rendered at the Hospital for qualifying patients. To obtain further information, including an application, please contact our customer service representatives.

You will receive written notice of the outcome of your case including reason/s if your case is rejected. You may reapply for free bed funds at any time. Additional funding may become available on an annual basis.

Other assistance options, such as a sliding scale discount may also apply to your situation. The financial counseling process will indicate available options to assist you with your outstanding balance.

ESTA USTED TENIENDO PROBLEMAS PAGANDO LOS BILES DEL HOSPITAL?

El Hospital de Waterbury le ofrece un programa llamado "Fondo de Cama Gratis" para cubrir el gasto parcial o completo a los pacientes que son internados, dado de alta o en emergencia que visitan el Hospital. Este programa solamente es para esas personas que califican. Para obtener más información, incluyendo una aplicación, por favor comuníquese con nuestra oficina de servicios al paciente en el horario indicado a continuación:
POR TELEFONO:
***203-573-7116, de lunes a viernes,* 8:30 a.m. to 3:30 p.m.**
CON CITA O SIN CITA:
Horario de la oficina: lunes a viernes, 8 a.m. a 4:30 p.m.
LAS OFICINAS DE ASISTENCIA AL PACIENTE ESTAN LOCALIZADAS EN LA PLANTA BAJA AL CRUZAR LA SALA DE ESPERA.

Usted recibirá una notificación indicando si su caso ha sido aprobado o negado. Fondos adicionales estarán disponibles anualmente.Otra opción de asistencia es la aplicación "Sliding Scale Discount" para su situación financiera. Esta aplicación es para ayudarle con al balance de su cuenta pendiente.

Asistencia adicional estará disponible en el Departamento de Servicio Social o Departamento de Salud.

ARE YOU UNINSURED?

If you meet the definition of "uninsured" as defined by Connecticut State statutes, section 19a-673, [effective October 1, 2003], you may be eligible to have your balance/s reduced.

1. You have one or more outstanding balances due to Waterbury Hospital.
2. You have applied and been denied eligibility for any medical or health care coverage provided by Medicaid or State Administered General Assistance [SAGA] due to failure to satisfy income or other eligibility requirements
    a. Proof of denial is required
3. You are not eligible for coverage for hospital services under any other health insurance program [including workers compensation, third-party liability, motor vehicle insurance]
4. Your household income is at or below 250% of the Federal Poverty Income Guidelines.
    a. Proof of income is required

To find out if you qualify, please contact us.

PATIENT FINANCIAL SERVICES

By phone at 203-573-7116, Monday through Friday, 8:30 a.m. to 3:30 p.m.
By appointment or walk-in in the Patient Financial Services office (ground floor adjacent to the Main Lobby) Monday through Friday, 8 a.m. to 4:30 p.m.

In addition, a handout is available upon request as Required By The State Of Ct, SB568. Forms are available in the storeroom – form # CN4457 for all registration points of service.

The information sheet must be available for anyone who requests information about discounts or free bed funds.

CATEGORY: Free Care Manual	POLICY: Free Care Policy Matrix
ORIGINATED: 10-4-06	REVIEWED: 06/10
REVISED: 10/06, 01/07, 01/08,01/10,06/10	RETIRED:

PATIENT ASSISTANCE POLICY

The Patient Assistance Policy governs the right of a patient to request assistance with unpaid balances.

- Patient expresses that they cannot pay the bill and either has or has not been granted a discount previously.
- Patient may or may not have insurance

Once a request has been made, Customer Service staff work with the patient/representative to determine the qualification for Waterbury Hospital's various programs below. As appropriate, cases are prepared and presented to the Patient Assistance Committee for review. Free bed funds are applied for full/partial approval.

Note: In cases of partial approval, patient may be asked to pay a nominal co-pay or deductible amount to reflect acknowledgement of responsibility towards outstanding debt.

DISCOUNT PROGRAMS

UNINSURED PATIENT POLICY

- Patient has no insurance
- Patient has been denied Medicaid/Saga

If Income is at or below 200% of the FPIG, patient will qualify for 100% discount.

If Income is >200% of the FPIG, refer to the Sliding Scale Matrix for discount guidance.

CHARITY CARE POLICY

Balances in aggregate totaling <$1000 and are.....

- Uncollectible Encounters
- Deceased, no estate
- Homeless, no information
- Pt has recently been granted T19

Balances in aggregate >$1000 do not need to be presented to PAC. Write off to appropriate Free Bed Fund

Cost to Charge Alias 2003
Charity Care Non FBF 2002

SELF PAY DISCOUNT POLICIES

PROMPT PAY DISCOUNT

- Patient has **NO** insurance

A prompt pay discount of 25% will be applied after full payment of the outstanding balance. Payment is required within 30 days of receipt of first statement.

This discount requires no financial application.

Bed Funds

AC Hopkins (Naugatuck)	2000
CH Smith (Anyone)	2001
Terry (Thomaston,Plymouth)	2004
Hayden (Southmayd Home)	2005
Hemingway (Watertown)	2006
Meigs (Anyone)	2007
MI Sperry (Anyone)	2008
Other (Anyone)	2009
Permanent (Anyone)	2010
RV Warner (Naugatuck)	2011
Scovill-Kingsbury(St John's)	2012

Prompt Pay Alias 2013

SLIDING SCALE

- Patient has **no** insurance
- Patient's income is **above** 200% poverty income guidelines or
- Patient has a balance/s after insurance.

****Individual Encounter Balance - <$200 - no discount applies****

Aggregate balances – $201 to $999 - patient must complete a financial application to qualify for sliding scale discount [self pay only] or charity care. Presentation to PAC not required.

Aggregate balances - >$1000 – patient must complete a financial application for sliding scale discount [self pay only] or presentation to PAC(bal after ins). Case can be presented to PAC a second time if the patient is unable to comply with payment arrangements on balance after discount.

Sliding Scale Alias 2014

Use the appropriate alias for specific Free Bed Fund write-offs

Waterbury Hospital
CREDIT & COLLECTION MANUAL

PATIENT ASSISTANCE COMMITTEE BYLAWS

CATEGORY: Credit & Collection	POLICY: Patient Assistance Committee Bylaws
REVIEWED: 06/10	REVISED: 01/07, 01/08, 01/10
RETIRED:	Comment:

ARTICLE I - IDENTIFICATION

The name of the Committee shall be The Waterbury Hospital Patient Assistance Committee, hereinafter referred to as the Patient Assistance Committee (PAC).

ARTICLE II - PURPOSE

The purpose of the Patient Assistance Committee is to review, on a monthly basis, applications for financial assistance, grant free care and where appropriate, allocate Free Bed Funds to those patients who are determined in need of such funds and meet donor-established restrictions.

ARTICLE III - MEMBERSHIP

The membership of the Patient Assistance Committee shall be Hospital employees, and multi-disciplinary in nature and include individuals qualified by training and/or experience to develop, implement, and maintain the Patient Assistance Committee.

SECTION 1. OFFICERS

The Officers of the Patient Assistance Committee shall be:

A. CHAIRPERSON

The Chairperson of the Committee shall be the Director of Patient Access/Financial Services, or Designee. This will ensure that applications are encouraged and reviewed thoroughly by Patient Access/ Financial Services.
The Chairperson shall have the responsibility of maintaining accurate records for patient encounters and allocation of Free Bed, to include a summary of each case presented, with outcome. Funds

Hardcopy Summary will be kept on file with the individual cases. Electronic summary will be kept and will be available to committee members on the hospital shared drive.

The Chairperson shall be a voting member of the Committee.

B. CASE PRESENTERS

These individuals shall be appointed by the Chairperson and shall have the responsibility to investigate and prepare cases for presentation to the PAC.
The Case Presenter is responsible for communicating the decisions of the PAC to applicants and to gather any additional information as requested by the PAC.

SECTION 2. DESIGNATION

The Chairperson and members of the Patient Assistance Committee shall be appointed by the Vice-President of Finance of the Waterbury Hospital and membership shall, from time to time, be increased or decreased or otherwise modified to reflect the changing needs of the Committee's functions.

SECTION 3. COMPOSITION

The following Departments, functions or services shall be represented on the Patient Assistance Committee:

- Vice-President Finance
- Finance
- Patient Access/ Financial Services
- Social Services
- Risk Management
- Patient Advocacy
- Behavioral Health

ARTICLE IV - MEETINGS

SECTION 1. MONTHLY MEETINGS

The Patient Assistance Committee will meet monthly, providing there are cases to be presented. The Committee will meet a minimum of once per quarter regardless of the case presentation. At that time, the Committee will review quarterly reports free care granted and availability of Free Bed Funds.

SECTION 2. NOTICE OF MEETINGS

The Chairperson shall distribute a reminder of the meetings in advance of the meeting date. Meetings are scheduled for the second Wednesday of each month, at 8 a.m.

SECTION 3. CASE REVIEW

The Case Presenters will deliver the packet of cases to be presented at least one day in advance of the meeting, to allow the PAC committee members time to review the cases.
Patient names are removed from the packets and cases are assigned a number following the presenter's initials.

SECTION 4. QUORUM

Fifty percent (50%) of the voting Patient Assistance Committee membership shall constitute a quorum at any monthly or special meeting. Such a quorum may transact any business properly brought before the Committee.

SECTION 5. PRESIDING OFFICER

The Chairperson, or designee, shall preside at all meetings of the Patient Assistance Committee. In their absence, they shall designate another member of the Committee to preside.

SECTION 6. INVITED GUESTS.

As deemed appropriate, guests may be invited to attend Patient Assistance Committee meetings to provide input and feedback regarding specific cases (i.e. Town Welfare Representatives). Invited guests participation will be limited to specific cases (due to patient confidentiality concerns), are not entitled to vote and are not Committee members.

ARTICLE V - OBJECTIVES

The objectives of the Patient Assistance Committee shall be to provide an avenue to objectively review applications/request for financial assistance and be the authoritative source for allocation of Free Bed Funds from such requests under the guidelines of the Free Care Policy.

ARTICLE VI - AMENDMENT TO THE RULES & REGULATIONS

These governing Rules and Regulations may be amended or revised by a simple majority of affirmative votes by the voting Patient Assistance Committee members, and approved by the President or designee of the Hospital.

ARTICLE VII – COMPLIANCE / RECORD-KEEPING

The chairperson shall insure that all state and federal regulations are followed in regards to the communication of free bed funds to patients.

In addition, all data required by the Office of Healthcare Access will be maintained for reporting purposes.

APPROVED:

_____

VICE-PRESIDENT, FINANCE

_____

CHAIRPERSON, PATIENT ASSISTANCE COMMITTEE

DATE REVISED: January 8, 1998, April 1999, January 2010

Waterbury Hospital
CREDIT & COLLECTION MANUAL

PATIENT ASSISTANCE POLICY

CATEGORY: Credit & Collection	**POLICY: Patient Assistance Policy**
ORIGINATED: 2/9/88	REVIEWED: 06/10
REVISED: May96, Jan98, Apr99, Apr00, Sep03, Jan07, Jan08, Dec09	RETIRED:

SCOPE: Patient Assistance process.
PURPOSE: To provide a mechanism to assist patients who do not meet the eligibility requirements for government assistance and who do not have the financial means to reimburse the hospital for services rendered. It is the responsibility of the Patient Accounts Department to properly notify patients of all government and hospital assistance programs, via printed material, signs and upon personal interview. **Assistance is not granted in advance of services**, and only applies to those Encounters included in the application.

POLICY: To ensure that all patients, who meet the eligibility requirements and have limited or no health benefit coverage, are informed of the Patient Assistance Program as an option for encounter resolution. This Patient Assistance Program is supplemented by available Free Bed funds.

POLICY GUIDELINES:

ELIGIBILITY:

All patients have the right to request that the Patient Assistance Committee hear their case. Patients who qualify as "uninsured" [see Uninsured Patient Policy] can also apply for free bed funding. Patients may reapply if rejected due to changes in financial circumstances.

Specific information regarding a patient's financial situation must be provided in order to determine if the patient qualifies for other assistance programs such as Medicaid or Saga, State of CT Uninsured Status [see Uninsured Patient policy], or sliding scale [internal hospital program]. The most current Federal Poverty Income Guidelines are utilized for all above programs. All self-pay balances are eligible regardless of encounter status including bad debts.

Categories of patients who would most often be eligible are:

- Self-pay patients who do not qualify for any other type of assistance programs after a financial determination.

- Patients with minimal insurance coverage who do not have the means available to resolve outstanding self-pay balances and who qualify based on financial review.

- Patients who have applied for government assistance and were denied [including timely filing denials] and either meet or do not meet all criteria for uninsured status.

- Patients who have applied for government assistance and granted, however, have open balances prior to the date granted. [These cases do not need to be presented to the committee; however, the allocation of funds is governed by the guidelines outlined in this policy. [see allocation of funds]

- Patients who would not qualify for government programs based on income or level of assets, but who would qualify based on personal hardship caused by a catastrophic medical situation.

PROCEDURE:
REFERRAL AND APPLICATION PROCESS
Patients requesting assistance can be referred from any source, however Patient Financial Services is responsible for the preparation and presentation of cases to the Patient Assistance Committee.

- All patients must complete a financial application that contains pertinent information such as:
  - Proofs of income i.e. pay stubs, tax returns [current and previous year], child support, social security checks, alimony etc.
  - A listing of outstanding expenses i.e. utilities, charge accounts, medical bills, cable bills etc.
  - Proof of assets i.e. checking and saving accounts, IRAs, annuities
- A complete financial packet would include the following (and may be modified from time to time):
  - Credit application
  - Denials from assistance programs
  - Back up for assets, liabilities
  - Tax Returns
  - All pertinent encounter comments
  - Other information necessary to make a determination.

Upon receiving a request for assistance, the Patient Financial Services Customer Service staff may assist the patient with the application or will review the application for

completeness and applicable encounters are placed on hold. Requests for additional information are made as necessary to complete the application. The patient is expected to return any additional information within 10 business days. The Customer Service Staff will contact the patient if information is not received timely, however, the case will be closed if patient is uncooperative. The patient may need to reapply.

DECEASED PATIENTS

The Patient Financial Services Customer Service Staff is responsible for documenting available resources (including estates, assets, or other available resources) to settle any encounters for deceased patients. For those deceased patients with no estate, assets or any form of reimbursement, the Customer Service Staff will summarize for the PAC the financial situation and the encounters eligible for free care.

The surviving spouse is required to complete a full financial application.

REVIEW AND PRESENTATION PROCESS:

Once the packets are reviewed and it has been determined that the patients have met all the criteria for presentation, the packets are copied and delivered in confidential packets, to the committee members so that they may review the material prior to the next meeting.

Patient names are removed and each case is given a number with presenter's initials i.e. SD1, LS1, EI1 etc..

The Patient Assistance Committee meets on the second Wednesday of each month. [See Patient Assistance Committee Bylaws for further information]

The Customer Service Staff presents cases. Each case is unique and is reviewed on its own merits, and discussed by the Patient Assistance Committee. Determinations are made as follows (independent of Free Bed Fund availability):

- 100% Approved - the entire outstanding balance is deemed free care.

- Partial Approvals - A percentage is determined to be free care, with payment arrangements and/or settlement on the balance.
    - Patient payment, either in lump sum or over time, is assigned at the discretion of the committee based on specific case criteria and subsequent discussion. Payment may be nominal or based on contracted rates.
        - **Nominal – copays or deductible amount/s to reflect acknowledgement of responsibility towards outstanding debt.**
        - **Other amount – In cases where there is indication of some assets/income, patient may be asked to pay an amount similar to Medicaid or another contracted rate.**

- Denials - the committee determines that the case does not qualify for free care based on the information presented. Patients will be denied if they do not complete all information requirements.

- Pending – cases that require more information or contact with the patient are pended until the information is obtained. If the patient does not comply with the information request, the application will be denied. The patient may need to reapply.

It is the expectation of the PAC that patients follow through on any program applications or grant-funded agencies such as The Waterbury Health Access Program [WHAP]. Cases may be approved or pended contingent on this expectation to avoid future outstanding debts.

NON-COMPLIANCE WITH PAYMENT OBLIGATIONS

Patients who do not comply with the committee's payment recommendations within 30 days of receipt of such information, and who do not contact the hospital for additional financial counseling, will be held liable for the balance prior to presentation to the committee.

Encounters that are in bad debt status and in the hands of an outside agency are pended from collection activity during the case preparation, presentation and PAC decision process.

ALLOCATION OF FREE BED FUNDS:

The Hospital has several Free Bed Funds available to support the provision of care to meet the needs of the poor and needy, as defined in the wills that established these funds. The funds available to support free care in a given year represent the income (interest and dividends) derived from the investment of these funds and disbursed by the Bank to the Hospital.

These Free Bed Funds will serve to support and supplement the free care granted by the Hospital in any given year, in accordance with the terms of the wills.

Once the case is approved for free care, Free Bed Funds are reviewed to determine if the patient meets any of the donor-established restrictions (i.e. town, church affiliation, etc.).

Determinations for free care are based on patient financial need and not fund availability. If a particular donor-restricted fund is not fully allocated during the year for qualifying applicants, the funds will be deployed to support other free care granted in accordance with the terms of the will.

The staff person presenting the case will notify the patients in writing of the committee's determination. The staff person will also initiate all write-off adjustment sheets.

The PAC chairperson will maintain minutes of each meeting to be kept on file. An electronic version will be available on the hospital shared drive for committee members. Patient confidentiality is observed.

In the case of partial approvals and denials, the staff person will remove the holds from the encounters so that the patient will begin to receive statements. Outsourced agencies will be notified of the PAC determination and will remove any holds so that dunning can resume.

RECORD-KEEPING

An Access database has been created to track all applications for uninsured and free bed funding. Staff is expected to record all patients who wish to be considered for uninsured status as well as all applications for free bed funds.

Fund usage will be maintained by the Finance department for reporting to appropriate free bed fund upon request or as required.

OHCA Filing Requirements

The Waterbury Hospital will comply with the filing and audit requirements of SB 568 as follows:

Annual Reporting

- Policies Regarding The Provision Of Free Or Reduced Cost Services, Excluding Medical Assistance Recipients
- Debt Collection Practices
- Number Of Applicants For Free And Reduced Cost Services
- Number Of Approved Applicants
- Total And Average Charges And Costs Of The Amount Of Free And Reduced Cost Care Provided
- As per SB 568 :"*Each hospital shall obtain an independent audit of the level of charges, payments and discharges by primary payer related to Medicare, medical assistance, Champus and non-governmental payers as well as the amount of uncompensated care including emergency assistance to families.*
- *The results of this audit including the above information, with an opinion, shall be provided to OHCA by each hospital together with the hospital's financial statements filed on February 28th of each year. The office shall evaluate the audit and may rely on the information contained in the independent audit or may require such additional audit as it deems necessary."*

Annual Compilation To Be Permanently Retained By The Hospital And Available To OHCA Upon Request.

- Number Of Applications For Hospital Bed Funds
- Number Of Patient Encounters [Patients] Receiving Hospital Bed Funds And The Actual Dollar Amounts Provided To Each Patient From Such Fund
- The Fair Market Value Of The Principal Of Each Individual Hospital Bed Fund Or The

Principal Attributable To Each Bed Fund If Held In A Pooled Investment

- The Total Earnings For Each Hospital Bed Fund Or The Earnings Attributable To Each Fund
- The Dollar Amount Of Earnings As Reinvested As Principal [If Any]
- The Dollar Amount Of Earnings Available For Patient Care
- Whether The Hospital Uses a Collection Agent As defined In Section 19a-509b Of The General Statutes, To Assist With Debt Collection.
- The Name Of Any Collection Agent Used
- The Hospital's Processes And Policies For Assigning A Debt To A Collection Agent And For Compensating Such Collection Agent For Services Rendered
- The Recovery Rate On Encounters Assigned To Collection Agents, Exclusive Of Medicare Encounters, In The Most Recent Hospital Fiscal Year.

Waterbury Hospital

CREDIT & COLLECTION MANUAL

Uncompensated Care Pool Regulations
Collections by hospitals from uninsured patients

Sec. 19a-673. (Formerly Sec. 19a-169e). Collections by hospitals from uninsured patients. (a) As used in this section:

(1) "Cost of providing services" means a hospital's published charges at the time of billing, multiplied by the hospital's most recent relationship of costs to charges as taken from the hospital's most recently available annual financial filing with the Office of Health Care Access.

(2) "Hospital" means an institution licensed by the Department of Public Health as a short-term general hospital.

(3) "Poverty income guidelines" means the poverty income guidelines issued from time to time by the United States Department of Health and Human Services.

(4) "Uninsured patient" means any person who is liable for one or more hospital charges whose income is at or below two hundred fifty per cent of the poverty income guidelines who (A) has applied and been denied eligibility for any medical or health care coverage provided under the state-administered general assistance program or the Medicaid program due to failure to satisfy income or other eligibility requirements, and (B) is not eligible for coverage for hospital services under the Medicare or CHAMPUS programs, or under any Medicaid or health insurance program of any other nation, state, territory or commonwealth, or under any other governmental or privately sponsored health or accident insurance or benefit program including, but not limited to, workers' compensation and awards, settlements or judgments arising from claims, suits or proceedings involving motor vehicle accidents or alleged negligence.

(b) No hospital that has provided health care services to an uninsured patient may collect from the uninsured patient more than the cost of providing services.

(c) Each collection agent, as defined in section 19a-509b, engaged in collecting a debt from a patient arising from services provided at a hospital shall provide written notice to such patient as to whether the hospital deems the patient an insured patient or an uninsured patient and the reasons for such determination.

(P.A. 94-9, S. 36, 41; P.A. 95-257, S. 12, 21, 58; June 18 Sp. Sess. P.A. 97-2, S. 96, 165; P.A. 03-266, S. 5; P.A. 04-76, S. 30; 04-257, S. 39.)

History: P.A. 94-9 effective April 1, 1994; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; Sec. 19a-169e transferred to Sec. 19a-673 in 1997; June 18 Sp. Sess. P.A. 97-2 made technical changes in Subdiv. (4) of Subsec. (a), effective July 1, 1997; P.A. 03-266 amended Subsec. (a)(1) by deleting "of an uninsured patient" and changing "audited financial statements" to "annual financial filing with the Office of Health Care Access", amended Subsec. (a)(4) by adding "who is liable for one or more hospital charges" and changing income level from two hundred per cent to two hundred fifty per cent, and added Subsec. (c) re written notice from collection agent; P.A. 04-76 amended Subsec. (a)(4)(A) by replacing reference to "general assistance program" with reference to "state-administered general assistance program"; P.A. 04-257 made a technical change in Subsec. (c), effective June 14, 2004.

Secs. 19a-674 and 19a-675. (Formerly Secs. 19a-170a and 19a-170b). Net revenue limit. Filings for partial or detailed budget review; hearings. Sections 19a-674 and 19a-675 are repealed, effective July 1, 2002.

(P.A. 94-9, S. 27, 28, 41; P.A. 95-160, S. 58, 69; 95-257, S. 39, 58; P.A. 96-139, S. 12, 13; P.A. 02-101, S. 20.)

Sec. 19a-676. (Formerly Sec. 19a-170c). Compliance with authorized revenue limits. For the fiscal year commencing October 1, 1992, and subsequent fiscal years, each hospital shall submit to the office, in the form and manner prescribed by the office, the data specified in section 19a-167g-91 of the regulations of Connecticut state agencies, as from time to time amended, the audit required under section 19a-649 and any other data required by the office.

(P.A. 94-9, S. 29, 41; 94-174, S. 11, 12; P.A. 95-160, S. 59, 69; 95-257, S. 39, 58; P.A. 96-139, S. 12, 13; 96-238, S. 1, 2, 25.)

History: P.A. 94-9 effective April 1, 1994; P.A. 94-174 amended Subsecs. (a) and (b) to eliminate hospitals' compliance payments for hospital fiscal years 1993 and 1994 and for January 1, 1995, to September 1, 1995, and subsequent fiscal years if a hospital exceeds its authorized net revenue limit, the excess shall be deducted from its net revenue limit in the next fiscal year or may be deducted from the hospital's disproportionate share-emergency assistance payments, effective June 6, 1994; P.A. 95-160 amended Subsecs. (a) and (b) to allow the Department of Social Services, in consultation with the Office of Policy and Management, to determine whether compliance shall be (1) deducted from the subsequent year's net revenue limit, (2) paid into the general fund or (3) deducted from payments to the hospital's Medicaid account, (2) and (3) being new Subdivs., effective June 1, 1995; P.A. 95-257 replaced Commission on Hospitals and Health Care with Office of Health Care Access, effective July 1, 1995; P.A. 96-139 changed effective

date of P.A. 95-160 but without affecting this section; P.A. 96-238 added Subsec. (b) exemption to making payments on an equal quarterly basis commencing fiscal year October 1, 1995, effective July 1, 1996, and further amended section to eliminate all revenue-limit compliance requirements except for data submission, effective October 1, 1997; Sec. 19a-170c transferred to Sec. 19a-676 in 1997.

Sec. 19a-676a. Termination of net revenue compliance payments. Section 19a-676a is repealed, effective July 1, 2002.

(P.A. 97-2, S. 1, 8; P.A. 02-89, S. 90; 02-101, S. 20.)

Sec. 19a-677. (Formerly Sec. 19a-170d). Computation of relative cost of hospitals. (a) (1) For the fiscal year commencing October 1, 1994, and subsequent fiscal years, the Office of Health Care Access shall assess the relative cost of hospitals as follows: For each hospital, actual net revenue shall be added to all discounts provided in accordance with subsection (c) of section 19a-646 for the year prior to the base year. The result of this calculation shall be defined as the hospital's adjusted net revenue.

(2) An adjustment shall be made to this adjusted net revenue to remove any costs which are noncomparable between hospitals. Such noncomparable costs may include, but are not limited to: Direct medical education costs, defined pursuant to Medicare principles, and physician expenses.

(3) The office shall adjust the results of subdivision (2) of this subsection to account for the variations in labor markets in which each hospital operates using the Medicare wage indices for the fiscal year, applied to the portion of the hospital's costs associated with wages, salaries and fringe benefits.

(4) The office shall adjust the results of subdivision (3) of this subsection for indirect medical education and disproportionate share using the adjustments for these costs applied by Medicare by dividing the result of subdivision (3) of this subsection by the ratio of the hospital's Medicare prospective payment system nonexempt inpatient operating payment per case after adjustment for indirect medical education and disproportionate share costs to the hospital's Medicare prospective payment system nonexempt inpatient operating payment per case prior to adjustment for indirect medical education and disproportionate share costs. The result shall be the final adjusted net revenue for the hospital.

(5) The office shall calculate the adjusted net revenue for each discharge, the average adjusted net revenue per discharge and the standard adjusted net revenue per discharge by utilizing the medical record abstract and billing data obtained pursuant to section 19a-654 or other information submitted by the hospitals to the office for the year prior to the base year. The adjusted net revenue for each discharge for a hospital shall be computed by multiplying the total charge for each discharge by the ratio of the final adjusted net revenue for the hospital calculated in subdivision (4) of this subsection over the total actual charges of the hospital for the year prior to the base year.

(6) The office may remove discharges which are determined to be outliers from subsequent calculations of the relative cost of hospitals. A discharge shall be defined as an outlier for this purpose if the final adjusted net revenue for a discharge is less than five hundred dollars or more than one hundred thousand dollars.

(7) The office shall calculate the average adjusted net revenue per discharge and the standard adjusted net revenue per discharge for each hospital. The average adjusted net revenue per discharge for a hospital shall be the sum of the adjusted net revenue for all discharges for a hospital divided by the total number of discharges for a hospital. The standard adjusted net revenue per discharge for a hospital shall be calculated as follows: The average adjusted net revenue per discharge for a diagnosis related group shall be the state-wide sum of the adjusted net revenue for each discharge assigned to a diagnosis related group divided by the state-wide total number of discharges assigned to the same diagnosis related group. The average adjusted net revenue per discharge for a diagnosis related group is then multiplied by the number of discharges assigned to the same diagnosis related group at the hospital. This is the expected adjusted hospital net revenue for a diagnosis related group. The total expected adjusted hospital net revenue is the sum of the expected adjusted hospital net revenue per discharge for all diagnosis related groups. The standard adjusted net revenue per discharge for a hospital is the total expected adjusted hospital net revenue divided by the total number of discharges for the hospital. The cost index for the hospital shall be the average adjusted net revenue per discharge for the hospital divided by the standard adjusted net revenue per discharge for the hospital.

(8) The hospitals shall be ranked based on the cost index resulting from subdivision (7) of this subsection.

(b) The office may establish a technical advisory group to advise it on the implementation of this section and on improvements to the methodology to measure the relative cost of hospitals. The office may develop an alternative methodology to measure the relative cost of hospitals which has the following properties: (1) Compares the relative cost of the hospitals in the state; (2) adjusts for case mix and the impact of direct and indirect medical education costs and the costs associated with treating a disproportionate share of poor patients; and (3) adjusts for labor market differences and other factors deemed by the office to result in justifiable differences in the costs of hospitals.

(c) The limit on the net revenue limit that a hospital may request in a detailed budget review shall be calculated as follows: The actual net revenue per equivalent discharge for the year prior to the base year shall be multiplied by the result of dividing 0.95 by the cost index calculated for the hospital pursuant to subdivision (7) of subsection (a) of this section, and the result shall be increased by the increase in the Consumer Price Index (CPI) from the year prior to the base year to the budget year.

(P.A. 94-9, S. 30, 41; P.A. 95-257, S. 39, 58.)

History: P.A. 94-9 effective April 1, 1994; P.A. 95-257 replaced Commission on Hospitals and Health Care with Office of Health Care Access, effective July 1, 1995; Sec. 19a-170d transferred to Sec. 19a-677 in 1997.

Sec. 19a-678. (Formerly Sec. 19a-170e). Inflation factor. Section 19a-678 is repealed, effective July 1, 2002.

(P.A. 94-9, S. 31, 41; P.A. 95-257, S. 39, 58; P.A. 02-101, S. 20.)

Sec. 19a-679. (Formerly Sec. 19a-170f). Computation of equivalent discharges. Inpatient and outpatient gross revenues and units of service. (a) For purposes of calculating the hospital's net revenue limit for the fiscal year commencing October 1, 1994, and subsequent fiscal years, the authorized number of equivalent discharges shall be:

(1) For a hospital exempt from detailed budget review the authorized equivalent discharges shall be the actual number of equivalent discharges in the year prior to the base year.

(2) For a hospital subject to partial budget review the authorized equivalent discharges shall be the actual number of equivalent discharges in the year prior to the base year plus the

authorized number of equivalent discharges associated with the approved certificate of need project or projects for which partial review is requested.

(b) Each hospital shall submit to the Office of Health Care Access inpatient and outpatient gross revenues and units of service separately for each hospital revenue center. For the fiscal years commencing October 1, 1993, and October 1, 1994, the units of service may be determined by the hospital. The office shall specify a standard list of units of service for use by each hospital in the fiscal year commencing October 1, 1995. For the fiscal year commencing October 1, 1995, hospitals shall report units of service based on both the list used in the fiscal year commencing October 1, 1994, and the standard list specified by the office for use in the fiscal year commencing October 1, 1995. For fiscal years commencing on and after October 1, 1996, all hospitals shall report units of service based exclusively on the standard list specified by the office, for use in the fiscal year commencing October 1, 1995. The timing and format of the submissions shall be specified by the office. In addition for the fiscal year commencing October 1, 1994, and subsequent fiscal years, these data shall be submitted on at least a quarterly basis in conjunction with the medical record abstract and billing data specified in subsection (b) of section 19a-654. The revenue centers shall be specified by the office.

(c) (1) For the fiscal year commencing October 1, 1994, "equivalent discharges" shall be defined as follows: The number of discharges for the fiscal year commencing October 1, 1992, times the ratio of the total gross revenue to the inpatient gross revenue for the same year. For compliance purposes for the fiscal year commencing October 1, 1993, the number of equivalent discharges shall be the actual number of discharges in the fiscal year commencing October 1, 1993, multiplied by the actual ratio of the total gross revenue to inpatient gross revenue for the first six months of the fiscal year commencing October 1, 1993. For compliance purposes for the fiscal year commencing October 1, 1994, the number of equivalent discharges shall be the actual number of discharges in the fiscal year commencing October 1, 1994, multiplied by the ratio of the total gross revenue to inpatient gross revenue specified in the budget authorization for the fiscal year commencing October 1, 1994.

(2) For the fiscal years commencing October 1, 1995, and October 1, 1996, "equivalent discharges" shall be defined as follows:

(A) For each revenue center providing services to outpatients, each outpatient unit of service shall be converted into a fraction of a discharge. The fraction shall be the ratio of the revenue per

unit of service in the revenue center to the inpatient revenue per inpatient discharge for the fiscal year commencing October 1, 1993.

(B) The number of outpatient equivalent discharges generated by the revenue center for the fiscal year shall be the product of the outpatient units of service for the revenue center for the fiscal year times the fraction calculated in subparagraph (A) of this subdivision for the revenue center for the fiscal year.

(C) The total number of outpatient equivalent discharges for the fiscal year for the hospital shall be the sum of all calculations pursuant to subparagraph (B) of this subdivision across all revenue centers. The total number of equivalent discharges for the hospital shall be defined as the number of outpatient equivalent discharges plus the number of inpatient discharges.

(P.A. 94-9, S. 33, 41; P.A. 95-257, S. 39, 58.)

History: P.A. 94-9 effective April 1, 1994; P.A. 95-257 replaced Commission on Hospitals and Health Care with Office of Health Care Access, effective July 1, 1995; Sec. 19a-170f transferred to Sec. 19a-679 in 1997.

Sec. 19a-680. (Formerly Sec. 19a-170g). Net revenue limit interim adjustment. Section 19a-680 is repealed, effective July 1, 2002.

(P.A. 94-9, S. 32, 41; P.A. 02-101, S. 20.)

DOCUMENT SOURCE: Office of Health Care Access
DOCUMENT NAME: Connecticut Chapter 368z
REVISED DATE: Unknown

Waterbury Hospital
CREDIT & COLLECTION MANUAL

UNINSURED PATIENT

CATEGORY: Credit & Collection	**POLICY: Uninsured Patient**
ORIGINATED: August 18, 2003	**REVIEWED: 06/10**
REVISED: March 2004, Jan 2007, Jan 2008, Nov 2009	**RETIRED: Uncompensated Care Policy is retired and replaced by Uninsured Patient**

SCOPE: Self pay patients who may qualify for reduction of balance if they meet the criteria for uninsured.
PURPOSE: To comply with SB 568 regarding determination of the uninsured patient by definition of Connecticut State statutes and to comply with State of Connecticut filing requirements.

POLICY:
It is the policy of The Waterbury Hospital to bill for services at cost if the patient meets the criteria of "uninsured" as set forth in SB 568.

CRITERIA: As defined in SB 568, "Uninsured patient" means

- Liability for one or more outstanding balances due to Waterbury Hospital.
- Patient has applied and been denied eligibility for any medical or health care coverage provided by Medicaid or State Administered General Assistance [SAGA] due to failure to satisfy income or other eligibility requirements
- An R&B denial of "over assets" is considered a valid denial.
- Patient is not eligible for coverage for hospital services under any health insurance program [including workers compensation, third-party liability, motor vehicle insurance]
- Household income is at or below 250% of the Federal Poverty Income Guidelines.
    - Proof of income and eligibility denial for Medicaid/SAGA is required
    - Signature validating information is required

NOTE: WATERBURY HOSPITAL HAS CHOSEN TO OFFER A HIGHER DISCOUNT THAN STATE REGULATIONS MANDATE:
If Income is at or below 200% of the FPIG, patient will qualify for 100% discount.
If Income is >200% of the FPIG, refer to the Sliding Scale Matrix for discount guidance.

Communication regarding the criteria will be printed on the back of all outgoing self pay statements [both at OSI and Bowne]. Signage in English and Spanish will also be posted in all registration areas

OSI Encounters
Self-pay Encounters that are referred to OSI will be placed on hold if the patient expresses financial difficulty. OSI will send out the Uninsured letter and form. The patient will have ten business days to return documentation.

Determination Process
Patients who are under consideration will meet with Customer Service and fill out the Financial Assistance form. All appropriate validating documentation MUST be available and reviewed.

Once the determination has been made, release the bill hold and put through the allowance.A letter is sent to the patient notifying them of the outcome of the determination.

Patients meet definition of "uninsured"
Write off will be determined based on comparison to the FPIG matrix. Income at or below 200% will qualify the patient for 100% write off.

Patients who do not meet or who do not respond
If determination cannot be made or patients do not meet criteria, patients will be responsible for full charges and are considered "insured" by definition of the statute. The patient will be dunned accordingly and the encounter will flow to bad debts if patient does not respond.

In **ALL** instances, whether the balance is cost or charge, patients may also apply for free bed funds. [See Patient Assistance Policy]

Bad Debts:
- Self pay patients who have not responded to the various hospital notices regarding qualification as an uninsured patient by Ct law or who do not meet the qualifications, will flow through the system as per routine collection processes and out to collection agencies.

- If after receiving notification from the collection agency, the patient wishes to be considered, the Encounter will be placed on hold. The collection agency will send an application to the patient. The hold will be removed in 30 days if the patient has not responded or provided the requested information.

- If the patient qualifies, the balance will be reduced based on the FPIG.

- If the patient does not qualify, the balance will remain the same and the Encounter will be returned to the agency. The Encounter will be transferred back to BD status.
- Routine collection efforts will ensue.

Documenting Encounter Activity
Encounters must be documented clearly and accurately with all action/s taken.

RECORD-KEEPING
An Access database has been created to track all applications for uninsured and free bed funding. Staff is expected to record all patients who wish to be considered for uninsured status as well as all applications for free bed funds.

Fund usage will be maintained by the Finance department for reporting to appropriate free bed fund upon request or as required.

OHCA Filing Requirements
The Waterbury Hospital will comply with the filing and audit requirements of SB 568 as follows:

Annual Reporting
- Policies Regarding The Provision Of Free Or Reduced Cost Services, Excluding Medical Assistance Recipients
- Debt Collection Practices
- Number Of Applicants For Free And Reduced Cost Services
- Number Of Approved Applicants
- Total And Average Charges And Costs Of The Amount Of Free And Reduced Cost Care Provided
- As per SB 568 :"*Each hospital shall obtain an independent audit of the level of charges, payments and discharges by primary payer related to Medicare, medical assistance, Champus and non-governmental payers as well as the amount of uncompensated care including emergency assistance to families.*
- *The results of this audit including the above information, with an opinion, shall be provided to OHCA by each hospital together with the hospital's financial statements filed on February 28th of each year. The office shall evaluate the audit and may rely on the information contained in the independent audit or may require such additional audit as it deems necessary."*

Annual Compilation To Be Permanently Retained By The Hospital And Available To OHCA Upon Request.
- Number Of Applications For Hospital Bed Funds
- Number Of Patient Encounters [Patients] Receiving Hospital Bed Funds And The Actual Dollar Amounts Provided To Each Patient From Such Fund
- The Fair Market Value Of The Principal Of Each Individual Hospital Bed Fund Or The Principal Attributable To Each Bed Fund If Held In A Pooled Investment
- The Total Earnings For Each Hospital Bed Fund Or The Earnings Attributable To Each Fund
- The Dollar Amount Of Earnings As Reinvested As Principal [If Any]
- The Dollar Amount Of Earnings Available For Patient Care
- Whether The Hospital Uses a Collection Agent As defined In Section 19a-509b Of The

General Statutes, To Assist With Debt Collection.

- The Name Of Any Collection Agent Used
- The Hospital's Processes And Policies For Assigning A Debt To A Collection Agent And For Compensating Such Collection Agent For Services Rendered
- The Recovery Rate On Encounters Assigned To Collection Agents, Exclusive Of Medicare Encounters, In The Most Recent Hospital Fiscal Year.

Date:

Dear Patient:

In order to determine if you meet the qualifications of an uninsured patient per the state of CT guidelines, we are providing you with the attached form. Please provide the following within 10 days:

Provide proof of denial from Medicaid
Complete the income information and provide proof of income.
Sign that the information is true and accurate and attest that you do not have any insurance coverage at this time.

Your signature attests to the accuracy of the information being provided.
We will review the information and contact you by mail when the determination is complete.

Thank you,

_____

Waterbury Hospital Health Center
Patient Financial Services

SAMPLE LETTERS

DATE:_____

_____

_____

_____

RE: PATIENT NAME:_____

Encounter Number _____

Total Charges $_____

Dear _____:

____ You have met the uninsured criteria set forth by State of Connecticut regulations, SB 568, and qualify for a reduction on the above Encounter. The balance due from you on the above Encounter will be $_____ which is the cost of providing services.

___ You have not met the criteria as defined by the State of Connecticut Uncompensated Care regulations, Public Act 94-9, Section 36, to qualify for a reduction on the above Encounter due to the following reason/s:

Payment in full on the above balance is expected. Please contact _____ at _____to set up payment arrangements. Thank you.

Very truly yours,

Patient Financial Services
Waterbury Hospital Health Center
P.O. Box 1590
Waterbury, CT. 06721

DATE:_____

_____

_____

_____

RE: PATIENT NAME:_____

Encounter Number _____

Total Charges $_____

Dear _____:

We have not yet received the documentation required in order to make a determination of uninsured status.

Please contact us as soon as possible at _____.

Collection efforts will resume if we do not hear from you.

Very truly yours,

The Waterbury Hospital
Patient Financial Services Department

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Patient Statement Policy

CATEGORY: Credit & Collection	Policy: Patient Statement Policy
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To provide the mechanism behind the dunning policy for self-pay balances, delinquency determinations, and the referral of unresolved self-pay balances to collection agencies.

I. POLICY

As part of its policy to 'Extend Reasonable Collection Effort(s)' Waterbury Hospital will generate patient statements and dun unresolved patient self-pay balances in accordance with the process cycle defined in this policy.

Waterbury Hospital utilizes the following means to properly dun patients and encourage self-pay balance payments and resolution:

1. Statement processing
2. Day One Self-pay Balance Outsourcing to NCO
3. Collection Agency referrals for delinquency patient balances

II. DEFINITIONS

Patient Statement Cycle

The patient statement begins when the:

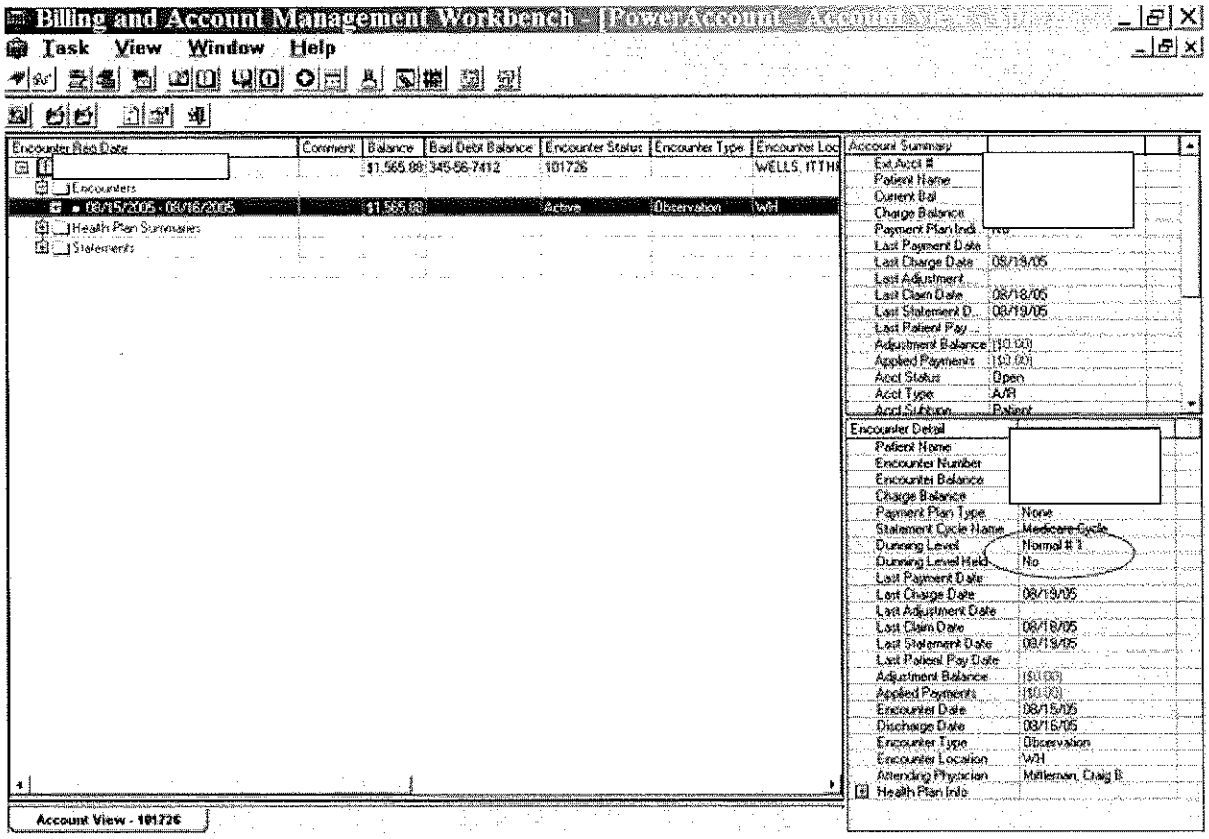
- Patient is discharged…**AND**
- Self-pay benefit order is ready to bill [all *other* insurance is complete] **OR**
- Primary insurance is billed

Dunning level

Dunning levels have two different meanings in Profit. When a statement cycle is created, a dunning level is assigned as follows:

- Normal #1 – Insurance is pending
- Normal #2 or any other dunning level – Non-insurance

These dunning levels are visible in the encounter grid on the right-hand side of the PowerAccount screen.



The second definition of dunning level applies to the context menu when there is a manual statement cycle change.

*Note: It is also advisable to **NOT** use the Dunning Level Held option. When placing statements on hold for any reason, use the HOLDS option and select General Hold All and put a reason.*

III. PROCEDURE

Patients are dunned in accordance with contractual agreements and regulatory requirements as follows:

1. Statements are generated for balances that are co-pays, deductibles and/or denials which are determined to be patient liable by the payer.
2. Medicaid patients are not dunned.

3. Valid workers compensation patients are not dunned.
4. Medicare requires a reasonable collection effort consistent with how other self-pay patients are handled. Per the Provider Reimbursement Manual, section 310.2, "If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."
    a. As with all other patients who have insurance, Medicare patients do not receive a statement until the balance is in self pay.

For all encounters, there are two situations where balances are referred to our outsourcing vendor for dunning and follow-up:

1. ***Electronic:*** Patient self-pay balances are referred to NCO after the first patient statement has been generated in Cerner and twenty (20) days have passed since the statement generation date.
2. ***Manual:*** Patient self-pay balances aged more than 60 days since the last bill date not previously referred to NCO (e.g., Day One Payment Plans, Statement Suppression Holds, Financial Assistance Requests, etc) will be referred to NCO manually by the Reporting Analyst or Patient Account Collector reviewing the encounter.

Note: To prevent processing delays of qualified self-pay encounters the Patient Accounts Reporting Analyst shall conduct monthly reviews of the Statement Suppression Hold report. Encounters that are held inappropriately shall be forwarded on to the Assistant Director of Patient Accounting for distribution to the Patient Accounting Staff. PAFS staff shall then review the encounter and remove the hold as necessary, while making certain to document their actions in Cerner.

Once the patient balance is referred to NCO, the patient will receive statements and phone calls [on larger balances] following their process for all self pay collection. If the account remains unpaid after all attempts at collection have failed, the balance will be returned for referral to a collection agency providing 120 days has elapsed since the first statement has been sent. The only exception to this rule would be if there is returned mail and no address can be found for the patient.

Note: When an encounter reaches the Collections level, statements cease and a statement suspension hold is automatically placed on the encounter. The encounter will then qualify for the Collection Preview queue in preparation for referral to bad debts.

Waterbury Hospital

PROFIT STATEMENT CYCLE INFORMATION

When does the statement cycle start?

An initial cycle is assigned as follows:

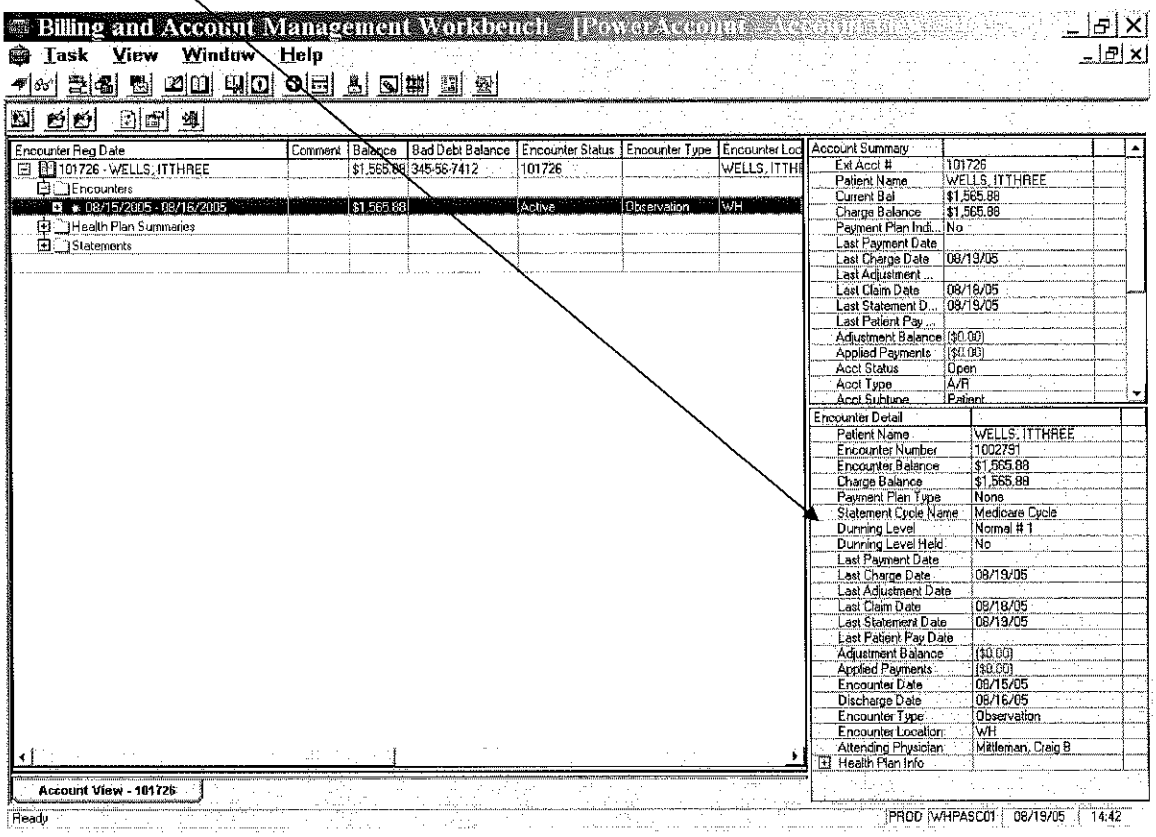
- Patient is discharged…**AND**
- Self pay benefit order is ready to bill [all insurance is complete] **OR**
- Primary insurance is billed

What is a Dunning level?

Dunning levels have two different meanings in Profit. When a statement cycle is created, a dunning level is assigned as follows:

- Normal #1 – Insurance is pending
- Normal #2 or any other dunning level – Non-insurance

These dunning levels are visible in the encounter grid on the right-hand side of the Poweraccount screen.



The second definition of dunning level applies to the context menu when there is a

manual statement cycle change. The change dunning level menu will reflect actual statement cycles.

It is also advisable to **NOT** use the Dunning Level Held option. When placing statements on hold for any reason, use the HOLDS option and select General Hold All and put a reason.

What constitutes an acceptable payment?

Acceptable payment is defined as any insurance payment, or an acceptable patient payment as defined by the formal and informal Payment Plan set up rules in the Billing Entity.

What are the formal and informal payment plan rules?

- Informal plan - The minimum acceptable payment is 100% of the total balance of the encounter.
    - When a patient pays less than 100% of the balance due on the encounter, the plan will default to Informal, and the unacceptable payment message will appear on statements.
- Formal plan – The minimum acceptable payment is 20% of the total balance of the encounter.

Payments made below these amounts are considered to be unacceptable.

What is a global message?

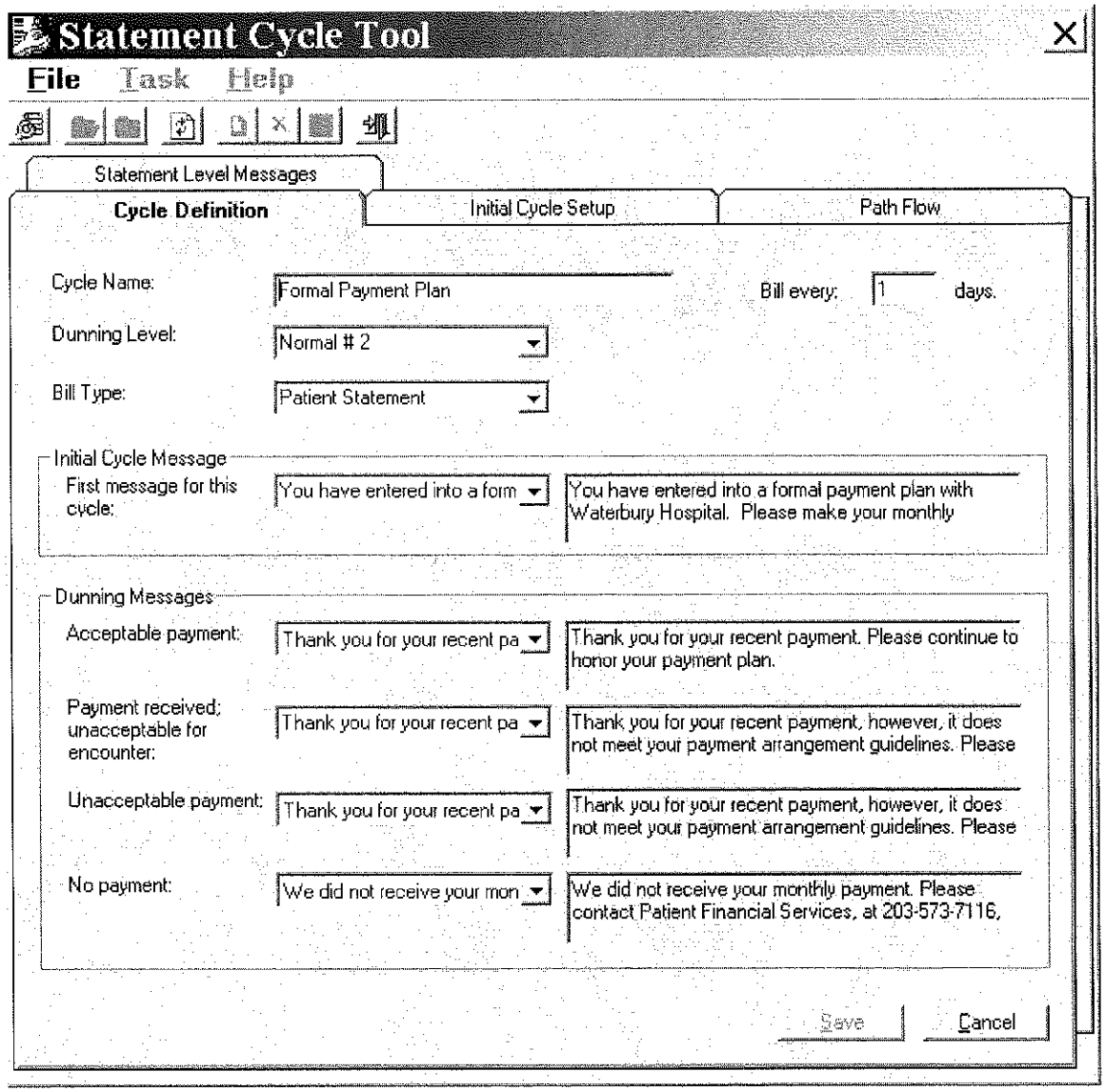
The global message appears on all statements regardless of the statement cycle or dunning level. For example, a global message might say the following – ***"Thank You for choosing Waterbury Hospital. We have recently moved to a new computer system. Please be patient."***

When an encounter reaches the Collections level, statements cease and a statement suspension hold is automatically placed on the encounter.

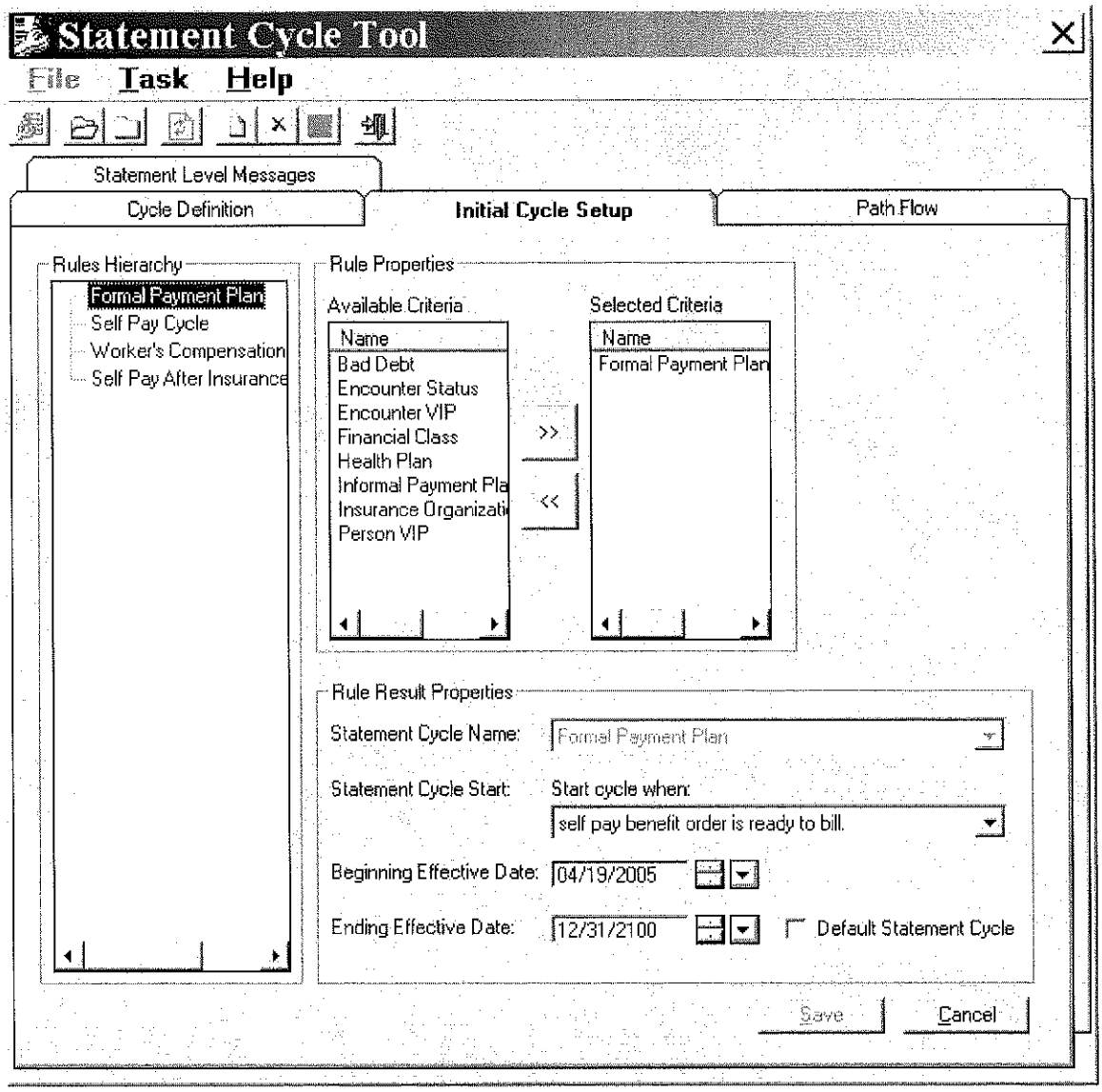
The encounter will then qualify for the Collection Preview queue in preparation for referral to bad debts.

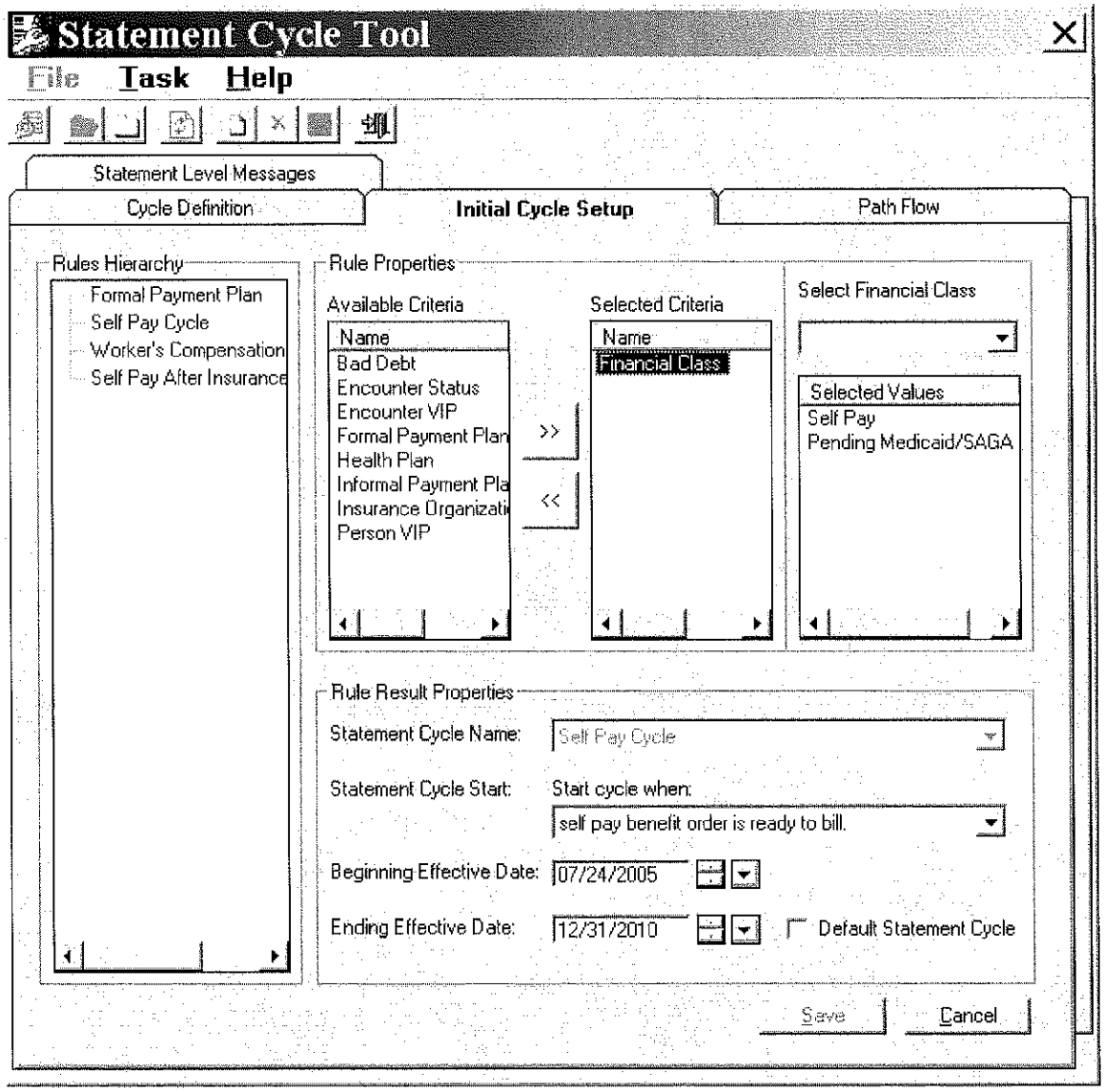
Note: Only encounters placed in formal payment plans or in the manual statement cycle will qualify for the Collection Preview queue.

The following is an example of a cycle definition within the statement tool:



This is the initial cycle set up from the Statement Tool:


Statement Cycle Tool
File
Task
Help
Statement Level Messages
Cycle Definition
Initial Cycle Setup
Path Flow
Rules Hierarchy
Formal Payment Plan
Self Pay Cycle
Worker's Compensation
Self Pay After Insurance
Rule Properties
Available Criteria
Name
Bad Debt
Encounter Status
Encounter VIP
Financial Class
Health Plan
Informal Payment Pla
Insurance Organizati
Person VIP
>>
<<
Selected Criteria
Name
Formal Payment Plan
Rule Result Properties
Statement Cycle Name:
Formal Payment Plan
Statement Cycle Start:
Start cycle when:
self pay benefit order is ready to bill.
Beginning Effective Date:
04/19/2005
Ending Effective Date:
12/31/2100
Default Statement Cycle
Save
Cancel


Statement Cycle Tool
File
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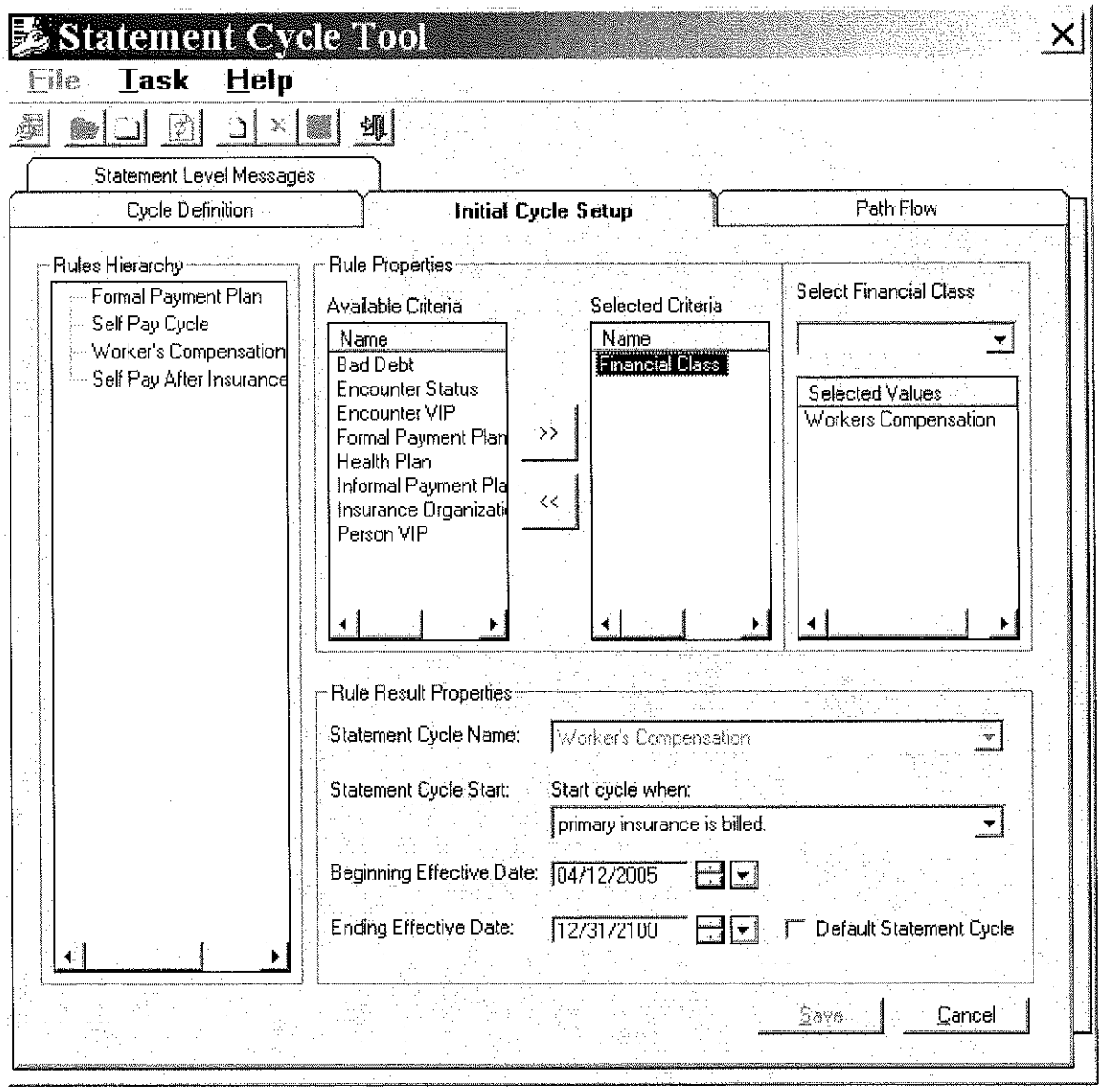
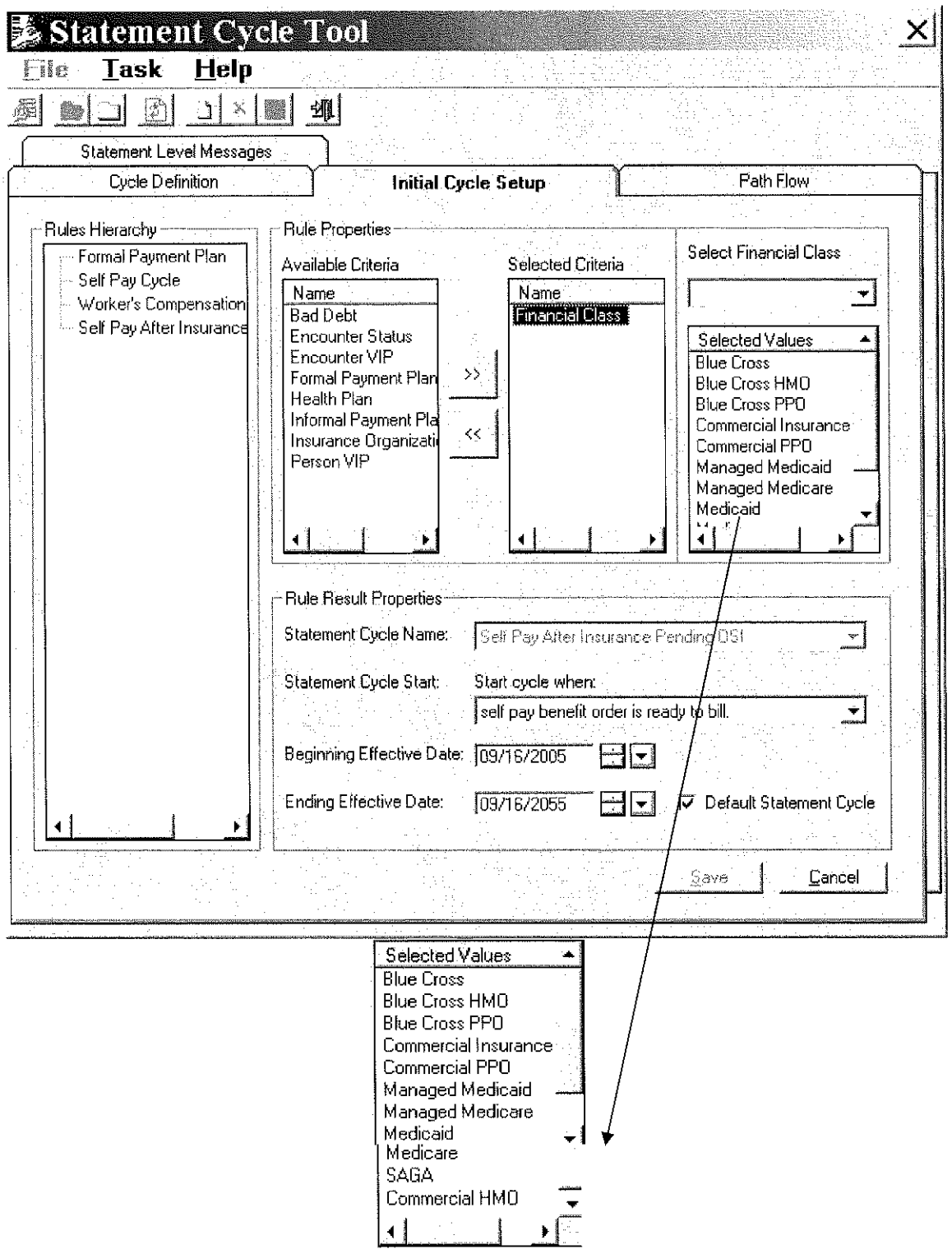
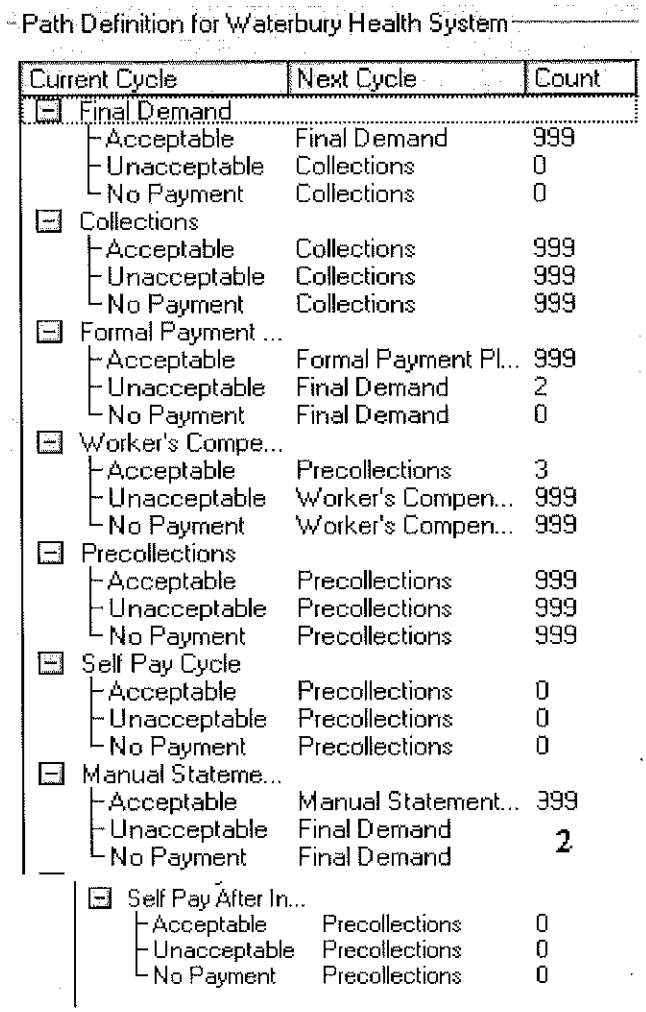
Help
Statement Level Messages
Cycle Definition
Initial Cycle Setup
Path Flow
Rules Hierarchy
Formal Payment Plan
Self Pay Cycle
Worker's Compensation
Self Pay After Insurance
Rule Properties
Available Criteria
Name
Bad Debt
Encounter Status
Encounter VIP
Formal Payment Plan
Health Plan
Informal Payment Pla
Insurance Organizati
Person VIP
>>
<<
Selected Criteria
Name
Financial Class
Select Financial Class
Selected Values
Self Pay
Pending Medicaid/SAGA
Rule Result Properties
Statement Cycle Name:
Self Pay Cycle
Statement Cycle Start:
Start cycle when:
self pay benefit order is ready to bill.
Beginning Effective Date:
07/24/2005
Ending Effective Date:
12/31/2010
Default Statement Cycle
Save
Cancel


Statement Cycle Tool
File
Task
Help
Statement Level Messages
Cycle Definition
Initial Cycle Setup
Path Flow
Rules Hierarchy
Formal Payment Plan
Self Pay Cycle
Worker's Compensation
Self Pay After Insurance
Rule Properties
Available Criteria
Name
Bad Debt
Encounter Status
Encounter VIP
Formal Payment Plan
Health Plan
Informal Payment Pla
Insurance Organizati
Person VIP
>>
<<
Selected Criteria
Name
Financial Class
Select Financial Class
Selected Values
Workers Compensation
Rule Result Properties
Statement Cycle Name:
Worker's Compensation
Statement Cycle Start:
Start cycle when:
primary insurance is billed.
Beginning Effective Date:
04/12/2005
Ending Effective Date:
12/31/2100
Default Statement Cycle
Save
Cancel


Statement Cycle Tool
File
Task
Help
Statement Level Messages
Cycle Definition
Initial Cycle Setup
Path Flow
Rules Hierarchy
Formal Payment Plan
Self Pay Cycle
Worker's Compensation
Self Pay After Insurance
Rule Properties
Available Criteria
Name
Bad Debt
Encounter Status
Encounter VIP
Formal Payment Plan
Health Plan
Informal Payment Pla
Insurance Organizati
Person VIP
>>
<<
Selected Criteria
Name
Financial Class
Select Financial Class
Selected Values
Blue Cross
Blue Cross HMO
Blue Cross PPO
Commercial Insurance
Commercial PPO
Managed Medicaid
Managed Medicare
Medicaid
Rule Result Properties
Statement Cycle Name:
Self Pay After Insurance Pending DSI
Statement Cycle Start:
Start cycle when:
self pay benefit order is ready to bill.
Beginning Effective Date:
09/16/2005
Ending Effective Date:
09/16/2055
Default Statement Cycle
Save
Cancel
Selected Values
Blue Cross
Blue Cross HMO
Blue Cross PPO
Commercial Insurance
Commercial PPO
Managed Medicaid
Managed Medicare
Medicaid
Medicare
SAGA
Commercial HMO

PATH DEFINITION



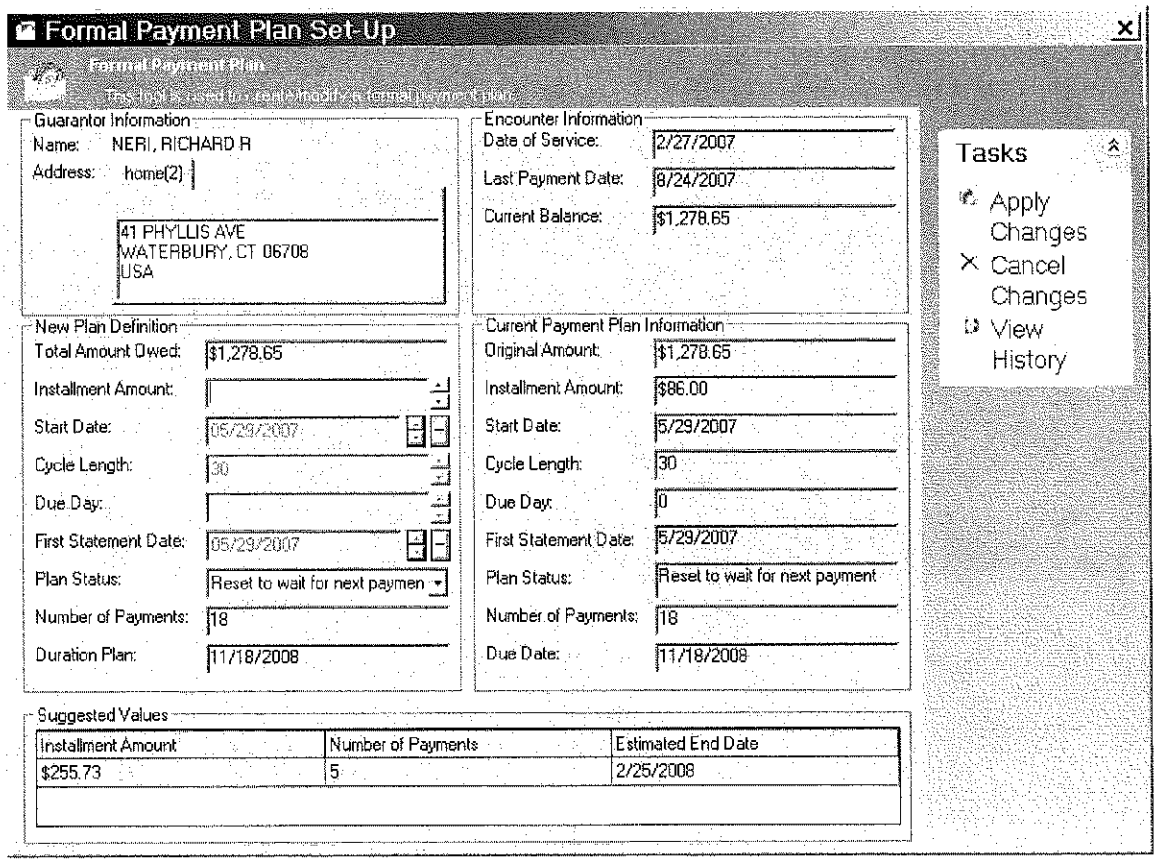
***** Unacceptable & No Payment for the Manual Statement Cycle changed from 3 to 2 on 9-26-07.**

FORMAL PAYMENT PLAN CHEAT SHEETS

Note the installment amount, beginning date and first statement date prior to researching Formal Plans. This information can be viewed in the right-hand grid or by opening up the formal plan.

Payment Plan Informati...	This Encounter is associated to a formal payment plan.
Original Amount Due	$1,536.65
Total Amount Due	$1,278.65
Installment Amount ...	$86.00
Beginning Date	5/29/2007
Duration Date	11/18/2008
Original Payment Pla...	5/29/2007
Duration	30
Current Plan Status	Reset to wait for next payment
Due Day	------
Number Of Payments	18

When a formal plan is set up the following messages



FORMAL PLAN MESSAGES

Initial Set Up Message This will be on the first statement sent after the formal plan is set up.	You have entered into a formal payment plan with Waterbury Hospital. Please make your monthly
Acceptable Payment Message The patient pays the installment amount within the established timeframe.	Thank you for your recent payment. Please continue to honor your payment plan.
Unacceptable Message The patient pays less than the installment amount within the established timeframe. Two instances of unacceptable payments allowed. After two, statement cycle will change to **FINAL DEMAND.**	Thank you for your recent payment, however, it does not meet your payment arrangement guidelines. Please
No Payment Message The patient makes no payment within established timeframe. One instance of no payment allowed. After first instance of no payment, statement cycle changes to **FINAL DEMAND.**	We did not receive your monthly payment. Please contact Patient Financial Services, at 203-573-7116.

MANUAL STATEMENT CYCLE MESSAGES

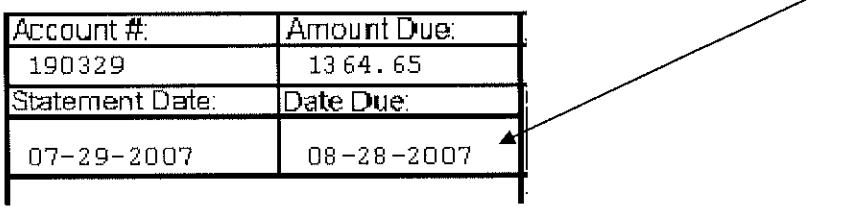
Initial Set Up Message This will be on the first statement sent after the encounter is set to Manual statement cycle.	This account has been reviewed and it has been determined that the balance is due from the patient.
Acceptable Payment Message The patient makes payment within the established timeframe.	Thank you for your recent payment. Please direct any inquries to 203-573-7116.
Unacceptable Message The patient pays less than 100% of the balance due within the established timeframe. Three instances of unacceptable payments allowed. After three, statement cycle will change to **FINAL DEMAND.**	Thank you for your recent payment, however, it does not meet our minimum guidelines. Please call Patient
No Payment Message The patient makes no payment within established timeframe. Three instances of no payment allowed. After three, the statement cycle changes to **FINAL DEMAND.**	Payment has not been received. Please contact our office at 203-573-7116 if you need financial assistance

FINAL DEMAND MESSAGES

Initial Set Up Message This will be on the first statement sent after the statement cycle drops to Final Demand.	**We have not received payment. Payment in full is expected. Please contact our office, at 203-573-7116 at your earliest convenience. Thank you. ****
Acceptable Payment Message The patient pays the installment amount within the established timeframe.	Thank you for your recent payment. Please direct any inquries to 203-573-7116.
Unacceptable Message The patient pays less than the installment amount within the established timeframe. One instance of unacceptable payments allowed. After one, statement cycle will change to **COLLECTION and statements stop.**	Thank you for your recent payment, however, it does not meet our minimum guidelines. Please call Patient
No Payment Message The patient makes no payment within established timeframe. One instance of no payment allowed. After first instance of no payment, statement cycle changes to **COLLECTION and statements stop.**	**We have not yet received payment. Please contact our office, at 203-573-7116 to prevent further collection efforts. Thank you. ****
	**** Messages changed 9-26-07**
Once the statement cycle changes to collection and the statements stop, the encounter will drop into the collection preview queue.	

It is important to remember the following when researching statements:

- A combination of payment, unacceptable payment and no payment can occur on the same encounter.
- Once the statement cycle drops to Final Demand, payments can continue and cycle will not advance to collection as long as acceptable payments are made within established timeframes.
- Timing is very important. Check the statement itself for the statement period



STATEMENT CYCLE MATRIX

Special Rules:

INITIAL CYCLE SET UP	CRITERIA	WHEN FIRST STATEMENT IS GENERATED
Workers Compensation	Fin Class = Workers Compensation	Primary insurance is billed
Self Pay Cycle	Self Pay, Pending Medicaid/Saga	Self pay benefit order is ready to bill
Formal Payment Plan	Formal Plan = Yes	Self pay benefit order is ready to bill
Self Pay after Insurance Pending OSI	All Fin Classes **Hold for 20 days after statement before qualifying for referral to OSI**	Self pay benefit order is ready to bill

STATEMENT CYCLE MATRIX

Bill at this level XX times before advancing > to the next cycle – Assume 30 day cycle

CYCLE	Dunning Level	ACCEPTABLE PAYMENT	UNACCEPTABLE PAYMENT	NO PAYMENT
Formal Payment Plan Initial cycle	Normal 2	999 > Formal Payment Plan	2 > Final Demand	1 > Final Demand
Workers Comp Initial cycle	Normal 1	3 > Precollections	3 > Workers Comp	3 – Workers Comp
Manual Statement Cycle Encounters which are returned from NCO or which are not NCO but must receive statements.	Normal 2	999 > Manual Statement Cycle	2> Final Demand * * changed from 3 to 2 on 10-5-07	2 > Final Demand * * changed from 3 to 2 on 10-5-07
Final Demand	Normal 2	999 > Final Demand	1 > Collections	1 > Collections
Self Pay Cycle Initial Cycle Self Pay no insurance assigned to NCO	Normal 2	0 > Precollections OSI	0 > Precollections OSI	0 > Precollections OSI
Precollections Encounter is now NCO Precollections	Precollections 1	999 > Precollections OSI	999 > Precollections OSI	999 > Precollections OSI
Self Pay after Insurance Pending OSI [NCO] Move to precollection at 25 days if balance remains unpaid	Normal 2	0>Precollections OSI	0>Precollections OSI	0>Precollections OSI
Collections	Collections 1	999 > Collections	999 > Collections	999 > Collections

Waterbury Hospital
CREDIT & COLLECTION MANUAL

PRICE QUOTING POLICY

CATEGORY: Credit & Collection	POLICY: PRICE QUOTING POLICY
ORIGINATED:01/07	REVIEWED:06/10
REVISED: 01/07; 10/07;06/10	RETIRED:

SCOPE: Price Quoting
PURPOSE: To provide estimated prices to patients upon request

POLICY: It is the policy of Waterbury Hospital to provide patients with good faith price estimations upon request.

PROCEDURE:

All requests for price quotes must be provided by Patient Financial Services.

Patients will be requested to provide as much information as possible, in order to determine the correct procedure/service price.

All price quotes are good faith estimations.

The following letter is used to confirm estimated price for services

WATERBURY HOSPITAL HEALTH CENTER
64 Robbins Street, Waterbury, CT 06708

Date:_____

_____
_____
_____

Estimated Price of Medical Procedure/Treatment

Dear_____:

On _____you contacted the Waterbury Hospital Health Center and requested the ESTIMATED PRICE of the following treatment.

PROCEDURE	**ESTIMATED PRICE**

At the time of your request, you were asked to identify the procedure/treatment that you were expected to undergo, and the importance of **obtaining a FULL AND ACCURATE DESCRIPTION OF THE PROCEDURE/TREATMENT** from your attending physician was stressed. This estimate is dependent on the extent of the information that you provide.

Based upon the information provided, you were given a **GOOD FAITH ESTIMATION,** which represents the typical cost associated with the procedure treatment. I also explained **that THE ACTUAL PRICE MAY VARY** and is dependent on the extent and nature of the procedure performed and any supplies and equipment utilized by your care provider. (Physician, etc.)

In the event that you have any other questions, or if I can be of further assistance, you may contact me at (203) 573- _____.

Sincerely,

Patient Financial Services Representative

Important: Please note that we are unable to provide price quotes for physicians and/or professional services that may be associated with the above. You will be billed separately for those services. Please contact your physician's office if necessary.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Bad Debt - Collection Agency Referral

CATEGORY: Credit & Collection	Policy: COLLECTION AGENCY REFERRAL
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To define the bad debt referral process and maximize cash flow by extending additional collection efforts on uncollectible encounters.

I. POLICY

It is the policy of Waterbury Hospital to transfer patient accounts with outstanding patient liability to bad debt only after all collections efforts have been exhausted. All encounters that are sent to bad debt will meet the standards outlined in the procedure below.

II. PROCEDURE

Once an encounter has been deemed uncollectible according to the Reasonable Collection Effort Policy Waterbury Hospital will refer unpaid patient-due balances [deductibles, co-payments, co-insurances] to collection agencies for additional collection efforts.

Encounters will be referred to Bad Debt Collections in one of two ways:

- ***Electronic:*** Encounters returned from NCO Outsourcing ***with*** cancel codes specific to bad debt, will be identified by the cancel code and routed automatically to one of the two collection agencies
  - Encounters with cancel code 81 will be routed to Connecticut Credit
  - Encounters with cancel code 84 will be routed to American Adjustment Bureau
- ***Manual:*** Encounters returned from NCO Outsourcing ***without*** cancel codes specific to bad debt, will be reviewed by follow-up staff. In the event that an encounter is returned for another reason. The encounter then needs to be referred to Bad Debts; this will be done annually by the Assistant Director of PAFS or the Reporting Analyst.

Waterbury Hospital staff and NCO (Self Pay vendor) will follow these general guidelines regarding the referral of overdue balances before moving the patient's account to collections:

- **Indigent or Medically Indigent Patients**: Waterbury Hospital will refer a patient to a collection agency unless it has been determined that the patient is uninsured, as per the state of Connecticut regulations governing free care. [PA 03-266].
- **Delinquency**: Waterbury Hospital must confirm that the patient account is delinquent (or 30 days past due).
- **Returned Mail**: The assumption is made that all statements, bills and letters reach the patient unless mail is returned. When returned mail is received, it is researched to find a current address. If mail is returned as undeliverable, and research does not produce a more current address, the encounter is placed manually into collection, regardless of age.
- **Bad Debt Determination Process**: Waterbury Hospital staff must confirm that the encounter has followed the Reasonable Collection Effort Policy before referring the encounter to a collection agency.
- **Disputes**: Waterbury Hospital and its collection agencies should be careful to make certain that the debt is not disputed or that there is not an insurance issue with which the Hospital and/or Collection Agency could resolve. If a patient indicates that they are experiencing health or financial difficulties, they should be referred to Waterbury Hospital Customer Service for Charity Care consideration or other alternate funding.
- **Letters of Protection**: As a rule, letters of protection are not accepted. Encounters that are in litigation for long periods of time should be referred to collection agencies unless the activity on the encounter warrants continued follow-up.

Waterbury Hospital is currently contracted with two collection agencies:

Connecticut Credit
90 National Drive, P.O. Box 1264
Glastonbury, CT 06033-6264
(800) 221-0405

American Adjustment Bureau
89 Willow Street, P.O. Box 2758
Waterbury, CT 06723
(203) 574-4200

1. Collection agencies will expend reasonable, tactful and diplomatic efforts to collect on overdue balances utilizing techniques available to them i.e. skip tracing, credit reporting, or predictive dialing.
2. If a collection agency believes that the patient balance should be pursued through litigation the agency will submit requests for approval to the Assistant Director of PAFS.
3. Payments made to Waterbury Hospital on bad debt encounters will be reported to the collection agencies on a daily basis via a vendor interface.
4. Payments made directly to collection agencies will be reported to Waterbury Hospital on monthly remittances.
5. All payments are gross and are posted directly to the patient encounters in the Cerner system.
6. Contracted fees will be remitted back to the collection agencies via special check request, approved by Director of PAFS and processed by the Accounts Payable Department.

7. Encounters can be recalled at any time due to specific situations with approval of Manager of Customer Service, Assistant Director of PAFS and/or Director of PAFS.
8. Statistics will be maintained on individual agencies to monitor patient complaints, liquidation and collection fee data. This report will be utilized to determine agency performance and recovery rates.

Note: Collection agencies must follow all pertinent regulations pertaining to debt collection to include Public Act 03-266, "An Act Concerning Hospital Billing Practices", effective 10-1-03. [See Uninsured Patient Policy]

Rebilling of Collection Agency Encounters Process:
It is expected that once Encounters are referred to collection agencies, the agencies will take over all aspects of handling the Encounter including billing or rebilling to third-parties.

In some cases encounters must be billed or rebilled by the hospital due to electronic media and contracts. If this should occur, the following will apply:

1. Collection agencies will provide third-party billing requests in writing
2. All required billing data must be provided by the agency and forwarded to the hospital immediately.
3. After billing has taken place, the encounters must be documented and the agency notified.
4. All requests for itemized bills can be honored by both agencies since both have access to the hospital system in their offices.
5. Collection agency staff may also come on-site to pull remittances for additional billing.

Settlement Request Procedure:
All efforts will be expended to collect all encounters in full, however when faced with an offer of settlement, the following guidelines will apply:

1. All facts, including assets and liabilities of the patient must be supplied.
2. The attorney making the settlement request must supply all documentation regarding the amount of the settlement.
3. Recommended settlement offers will be approved by the Director of PAFS (or the Assistant Director of PAFS if the Director is not available) based on the amount of the settlement and the balance due.

The following steps should be taken prior to the enactment of legal action:

1. Patient is sent an initial notice identifying the collection agency and the balance currently due the Hospital.
2. If there is no response to the initial notice, attempts are made to reach the patient by phone.
3. A second letter is generated thirty-one days after the initial letter and there are continued attempts to reach the patient by phone.
4. A third letter is generated fourteen days after the second.

5. If the agency is successful in getting a response from the patient, they determine if the patient agrees that the debt is due. If they agree, the agency attempts to enter into a repayment schedule.
6. When the patient agrees to repay their debt, the payment arrangement is monitored through a series of reminder notices. Additional follow up letters and phone calls are made if the payments become delinquent.
7. If the payment arrangement is not kept and several attempts have been made by phone and letter to bring the payments current, the agency recommends that the Hospital review the encounter. A determination is then made to forward the encounter to an attorney.
8. The agency might also ask the Hospital to review the file for referral to a collection attorney if they were never able to make contact with the patient through letters and phone calls and it had been determined that the patient had assets which justified suit being filed. These patients would have received a minimum of three letters over a 45-day period of time along with numerous attempts to reach them by phone.

Note: Typically, all attempts are made over a 90 to 120 day time period before considering this last course of action.

Compensation
Both Connecticut Credit and American Adjustment Bureau charge fees on a contingency basis. All monies collected by the agencies are forwarded to Waterbury Hospital on a monthly basis, along with an invoice for fees on encounters paid directly to Waterbury Hospital. All encounters are detailed on a monthly statement.

Bad Debt - Collection Agency Returns
Waterbury Hospital receives reports and/or electronic files on a periodic basis, identifying encounters that are deemed to be uncollectible by the collection agency. Agency contracts will stipulate the criteria for returning accounts to Waterbury Hospital which in most cases is one year [12 months] if there is no activity on the patient account.

Note: Waterbury Hospital reserves the right to audit and inspect encounters placed for collection with outside agencies.

Note: Waterbury Hospital will maintain accurate records reflecting which collection agency has been assigned to each encounter. Once encounters are assigned to an agency the agency must not be removed or changed unless by management for valid reason.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

The Fair Debt Collection Practices Act
As amended by Pub. L. 109-351, §§ 801-02, 120 Stat. 1966 (2006)

Purpose: To describe the standards by which Waterbury Hospital Patient Accounting, Patient Access staff and outsourced collections vendors will solicit or request patient co-payment or co-insurance obligations.

I. POLICY

Waterbury Hospital Patient Accounting, Patient Access staff and outsourced collections vendors will adhere to the policies set forth in the complete text of the Fair Debt Collection Practices Act (FDCPA) when soliciting or requesting patient co-payment or co-insurance obligations.

II. PROCEDURE

Waterbury Hospital Patient Accounting, Patient Access staff and outsourced collections vendors will refer to the complete text of the Fair Debt Collection Practices Act (FDCPA) detailed below.

III. FAIR DEBT COLLECTION PRACTICES ACT (FDCPA) ADDENDUM

As a public service, the staff of the Federal Trade Commission (FTC) has prepared the following complete text of the Fair Debt Collection Practices Act (FDCPA), 15 U.S.C. §§ 1692-1692p.

Please note that the format of the text differs in minor ways from the U.S. Code and West's U.S. Code Annotated. For example, this version uses FDCPA section numbers in the headings. In addition, the relevant U.S. Code citation is included with each section heading. Although the staff has made every effort to transcribe the statutory material accurately, this compendium is intended as a convenience for the public and not a substitute for the text in the U.S. Code.

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§ 817 Exemption for State regulation
§ 818 Exception for certain bad check enforcement programs operated by private entities
§ 819 Effective date

§ 801 15 USC 1601 note

§ 801. Short Title

This title may be cited as the "Fair Debt Collection Practices Act."

§ 802. Congressional findings and declaration of purpose

(a) There is abundant evidence of the use of abusive, deceptive, and unfair debt collection practices by many debt collectors. Abusive debt collection practices contribute to the number of personal bankruptcies, to marital instability, to the loss of jobs, and to invasions of individual privacy.

(b) Existing laws and procedures for redressing these injuries are inadequate to protect consumers.

(c) Means other than misrepresentation or other abusive debt collection practices are available for the effective collection of debts.

(d) Abusive debt collection practices are carried on to a substantial extent in interstate commerce and through means and instrumentalities of such commerce. Even where abusive debt collection practices are purely intrastate in character, they nevertheless directly affect interstate commerce.

(e) It is the purpose of this title to eliminate abusive debt collection practices by debt collectors, to insure that those debt collectors who refrain from using abusive debt collection practices are not competitively disadvantaged, and to promote consistent State action to protect consumers against debt collection abuses.

§ 803. Definitions

As used in this title—

(1) The term "Commission" means the Federal Trade Commission.

(2) The term "communication" means the conveying of information regarding a debt directly or indirectly to any person through any medium.

(3) The term "consumer" means any natural person obligated or allegedly obligated to pay any debt.

(4) The term "creditor" means any person who offers or extends credit creating a debt or to whom a debt is owed, but such term does not include any person to the extent that he receives an assignment or transfer of a debt in default solely for the purpose of facilitating collection of such debt for another.

(5) The term "debt" means any obligation or alleged obligation of a consumer to pay money arising out of a transaction in which the money, property, insurance or services which are

the subject of the transaction are primarily for personal, family, or household purposes, whether or not such obligation has been reduced to judgment.

(6) The term "debt collector" means any person who uses any instrumentality of interstate commerce or the mails in any business the principal purpose of which is the collection of any debts, or who regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due another. Notwithstanding the exclusion provided by clause (F) of the last sentence of this paragraph, the term includes any creditor who, in the process of collecting his own debts, uses any name other than his own which would indicate that a third person is collecting or attempting to collect such debts. For the purpose of section 808(6), such term also includes any person who uses any instrumentality of interstate commerce or the mails in any business the principal purpose of which is the enforcement of security interests. The term does not include—

(A) any officer or employee of a creditor while, in the name of the creditor, collecting debts for such creditor;

(B) any person while acting as a debt collector for another person, both of whom are related by common ownership or affiliated by corporate control, if the person acting as a debt collector does so only for persons to whom it is so related or affiliated and if the principal business of such person is not the collection of debts;

(C) any officer or employee of the United States or any State to the extent that collecting or attempting to collect any debt is in the performance of his official duties;

(D) any person while serving or attempting to serve legal process on any other person in connection with the judicial enforcement of any debt;

(E) any nonprofit organization which, at the request of consumers, performs bona fide consumer credit counseling and assists consumers in the liquidation of their debts by receiving payments from such consumers and distributing such amounts to creditors; and

(F) any person collecting or attempting to collect any debt owed or due or asserted to be owed or due another to the extent such activity

(i) is incidental to a bona fide fiduciary obligation or a bona fide escrow arrangement;

(ii) concerns a debt which was originated by such person;

(iii) concerns a debt which was not in default at the time it was obtained by such person; or

(iv) concerns a debt obtained by such person as a secured party in a commercial credit transaction involving the creditor.

(7) The term "location information" means a consumer's place of abode and his telephone number at such place, or his place of employment.

(8) The term "State" means any State, territory, or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or any political subdivision of any of the foregoing.

§ 804. Acquisition of location information

Any debt collector communicating with any person other than the consumer for the purpose of acquiring location information about the consumer shall—

(1) identify himself, state that he is confirming or correcting location information concerning the consumer, and, only if expressly requested, identify his employer;

(2) not state that such consumer owes any debt;

(3) not communicate with any such person more than once unless requested to do so by such person or unless the debt collector reasonably believes that the earlier response of such person is erroneous or incomplete and that such person now has correct or complete location information;

(4) not communicate by post card;

(5) not use any language or symbol on any envelope or in the contents of any communication effected by the mails or telegram that indicates that the debt collector is in the debt collection business or that the communication relates to the collection of a debt; and

(6) after the debt collector knows the consumer is represented by an attorney with regard to the subject debt and has knowledge of, or can readily ascertain, such attorney's name and address, not communicate with any person other than that attorney, unless the attorney fails to respond within a reasonable period of time to the communication from the debt collector.

§ 805. Communication in connection with debt collection

(a) COMMUNICATION WITH THE CONSUMER GENERALLY. Without the prior consent of the consumer given directly to the debt collector or the express permission of a court of competent jurisdiction, a debt collector may not communicate with a consumer in connection with the collection of any debt—

(1) at any unusual time or place or a time or place known or which should be known to be inconvenient to the consumer. In the absence of knowledge of circumstances to the contrary, a debt collector shall assume that the convenient time for communicating with a consumer is after 8 o'clock antimeridian and before 9 o'clock postmeridian, local time at the consumer's location;

(2) if the debt collector knows the consumer is represented by an attorney with respect to such debt and has knowledge of, or can readily ascertain, such attorney's name and address, unless the attorney fails to respond within a reasonable period of time to a communication from the debt collector or unless the attorney consents to direct communication with the consumer; or

(3) at the consumer's place of employment if the debt collector knows or has reason to know that the consumer's employer prohibits the consumer from receiving such communication.

(b) COMMUNICATION WITH THIRD PARTIES. Except as provided in section 804, without the prior consent of the consumer given directly to the debt collector, or the express permission of a court of competent jurisdiction, or as reasonably necessary to effectuate a postjudgment judicial remedy, a debt collector may not communicate, in connection with the collection of any debt, with any person other than a consumer, his attorney, a consumer reporting agency if otherwise permitted by law, the creditor, the attorney of the creditor, or the attorney of the debt collector.

(c) CEASING COMMUNICATION. If a consumer notifies a debt collector in writing that the consumer refuses to pay a debt or that the consumer wishes the debt collector to cease further

communication with the consumer, the debt collector shall not communicate further with the consumer with respect to such debt, except—

(1) to advise the consumer that the debt collector's further efforts are being terminated;

(2) to notify the consumer that the debt collector or creditor may invoke specified remedies which are ordinarily invoked by such debt collector or creditor; or

(3) where applicable, to notify the consumer that the debt collector or creditor intends to invoke a specified remedy.

If such notice from the consumer is made by mail, notification shall be complete upon receipt.

(d) For the purpose of this section, the term "consumer" includes the consumer's spouse, parent (if the consumer is a minor), guardian, executor, or administrator.

§ 806. Harassment or abuse

A debt collector may not engage in any conduct the natural consequence of which is to harass, oppress, or abuse any person in connection with the collection of a debt. Without limiting the general application of the foregoing, the following conduct is a violation of this section:

(1) The use or threat of use of violence or other criminal means to harm the physical person, reputation, or property of any person.

(2) The use of obscene or profane language or language the natural consequence of which is to abuse the hearer or reader.

(3) The publication of a list of consumers who allegedly refuse to pay debts, except to a consumer reporting agency or to persons meeting the requirements of section 603(f) or 604(3)[1] of this Act.

(4) The advertisement for sale of any debt to coerce payment of the debt.

(5) Causing a telephone to ring or engaging any person in telephone conversation repeatedly or continuously with intent to annoy, abuse, or harass any person at the called number.

(6) Except as provided in section 804, the placement of telephone calls without meaningful disclosure of the caller's identity.

§ 807. False or misleading representations

A debt collector may not use any false, deceptive, or misleading representation or means in connection with the collection of any debt. Without limiting the general application of the foregoing, the following conduct is a violation of this section:

(1) The false representation or implication that the debt collector is vouched for, bonded by, or affiliated with the United States or any State, including the use of any badge, uniform, or facsimile thereof.

(2) The false representation of—

(A) the character, amount, or legal status of any debt; or

(B) any services rendered or compensation which may be lawfully received by any debt collector for the collection of a debt.

(3) The false representation or implication that any individual is an attorney or that any communication is from an attorney.

(4) The representation or implication that nonpayment of any debt will result in the arrest or imprisonment of any person or the seizure, garnishment, attachment, or sale of any

property or wages of any person unless such action is lawful and the debt collector or creditor intends to take such action.

(5) The threat to take any action that cannot legally be taken or that is not intended to be taken.

(6) The false representation or implication that a sale, referral, or other transfer of any interest in a debt shall cause the consumer to—

(A) lose any claim or defense to payment of the debt; or

(B) become subject to any practice prohibited by this title.

(7) The false representation or implication that the consumer committed any crime or other conduct in order to disgrace the consumer.

(8) Communicating or threatening to communicate to any person credit information which is known or which should be known to be false, including the failure to communicate that a disputed debt is disputed.

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1. Section 604(3) has been renumbered as Section 604(a)(3).

(9) The use or distribution of any written communication which simulates or is falsely represented to be a document authorized, issued, or approved by any court, official, or agency of the United States or any State, or which creates a false impression as to its source, authorization, or approval.

(10) The use of any false representation or deceptive means to collect or attempt to collect any debt or to obtain information concerning a consumer.

(11) The failure to disclose in the initial written communication with the consumer and, in addition, if the initial communication with the consumer is oral, in that initial oral communication, that the debt collector is attempting to collect a debt and that any information obtained will be used for that purpose, and the failure to disclose in subsequent communications that the communication is from a debt collector, except that this paragraph shall not apply to a formal pleading made in connection with a legal action.

(12) The false representation or implication that accounts have been turned over to innocent purchasers for value.

(13) The false representation or implication that documents are legal process.

(14) The use of any business, company, or organization name other than the true name of the debt collector's business, company, or organization.

(15) The false representation or implication that documents are not legal process forms or do not require action by the consumer.

(16) The false representation or implication that a debt collector operates or is employed by a consumer reporting agency as defined by section 603(f) of this Act.

§ 808. Unfair practices

A debt collector may not use unfair or unconscionable means to collect or attempt to collect any debt. Without limiting the general application of the foregoing, the following conduct is a violation of this section:

(1) The collection of any amount (including any interest, fee, charge, or expense incidental to the principal obligation) unless such amount is expressly authorized by the agreement creating the debt or permitted by law.

(2) The acceptance by a debt collector from any person of a check or other payment instrument postdated by more than five days unless such person is notified in writing of the debt collector's intent to deposit such check or instrument not more than ten nor less than three business days prior to such deposit.

(3) The solicitation by a debt collector of any postdated check or other postdated payment instrument for the purpose of threatening or instituting criminal prosecution.

(4) Depositing or threatening to deposit any postdated check or other postdated payment instrument prior to the date on such check or instrument.

(5) Causing charges to be made to any person for communications by concealment of the true propose of the communication. Such charges include, but are not limited to, collect telephone calls and telegram fees.

(6) Taking or threatening to take any nonjudicial action to effect dispossession or disablement of property if—

(A) there is no present right to possession of the property claimed as collateral through an enforceable security interest;

(B) there is no present intention to take possession of the property; or

(C) the property is exempt by law from such dispossession or disablement.

11 § 808 15 USC 1692f (7) Communicating with a consumer regarding a debt by post card.

(8) Using any language or symbol, other than the debt collector's address, on any envelope when communicating with a consumer by use of the mails or by telegram, except that a debt collector may use his business name if such name does not indicate that he is in the debt collection business.

§ 809. Validation of debts

(a) Within five days after the initial communication with a consumer in connection with the collection of any debt, a debt collector shall, unless the following information is contained in the initial communication or the consumer has paid the debt, send the consumer a written notice containing—

(1) the amount of the debt;

(2) the name of the creditor to whom the debt is owed;

(3) a statement that unless the consumer, within thirty days after receipt of the notice, disputes the validity of the debt, or any portion thereof, the debt will be assumed to be valid by the debt collector;

(4) a statement that if the consumer notifies the debt collector in writing within the thirty-day period that the debt, or any portion thereof, is disputed, the debt collector will obtain verification of the debt or a copy of a judgment against the consumer and a copy of such verification or judgment will be mailed to the consumer by the debt collector; and

(5) a statement that, upon the consumer's written request within the thirty-day period, the debt collector will provide the consumer with the name and address of the original creditor, if different from the current creditor.

(b) If the consumer notifies the debt collector in writing within the thirty-day period described in subsection (a) that the debt, or any portion thereof, is disputed, or that the consumer requests the name and address of the original credi-12 § 809 15 USC 1692g tor, the debt collector shall cease collection of the debt, or any disputed portion thereof, until the debt collector obtains verification of the debt or any copy of a judgment, or the name and address of the original creditor, and a copy of such verification or judgment, or name and address of the original creditor, is mailed to the consumer by the debt collector. Collection activities and communications that do not otherwise violate this title may continue during the 30-day period referred to in subsection (a) unless the consumer has notified the debt collector in writing that the debt, or any portion of the debt, is disputed or that the consumer requests the name and address of the original creditor. Any collection activities and communication during the 30-day period may not overshadow or be inconsistent with the disclosure of the consumer's right to dispute the debt or request the name and address of the original creditor.

(c) The failure of a consumer to dispute the validity of a debt under this section may not be construed by any court as an admission of liability by the consumer.

(d) A communication in the form of a formal pleading in a civil action shall not be treated as an initial communication for purposes of subsection (a).

(e) The sending or delivery of any form or notice which does not relate to the collection of a debt and is expressly required by the Internal Revenue Code of 1986, title V of Gramm-Leach-Bliley Act, or any provision of Federal or State law relating to notice of data security breach or privacy, or any regulation prescribed under any such provision of law, shall not be treated as an initial communication in connection with debt collection for purposes of this section.

§ 810. Multiple debts

If any consumer owes multiple debts and makes any single payment to any debt collector with respect to such debts, such debt collector may not apply such payment to any debt which is disputed by the consumer and, where applicable, shall apply such payment in accordance with the consumer's directions.

§ 811. Legal actions by debt collectors

(a) Any debt collector who brings any legal action on a debt against any consumer shall—

(1) in the case of an action to enforce an interest in real property securing the consumer's obligation, bring such action only in a judicial district or similar legal entity in which such real property is located; or

(2) in the case of an action not described in paragraph (1), bring such action only in the judicial district or similar legal entity—

(A) in which such consumer signed the contract sued upon; or

(B) in which such consumer resides at the commencement of the action.

(b) Nothing in this title shall be construed to authorize the bringing of legal actions by debt collectors.

§ 812. Furnishing certain deceptive forms

(a) It is unlawful to design, compile, and furnish any form knowing that such form would be used to create the false belief in a consumer that a person other than the creditor of such consumer is participating in the collection of or in an attempt to collect a debt such consumer allegedly owes such creditor, when in fact such person is not so participating.

(b) Any person who violates this section shall be liable to the same extent and in the same manner as a debt collector is liable under section 813 for failure to comply with a provision of this title.

§ 813. Civil liability

(a) Except as otherwise provided by this section, any debt collector who fails to comply with any provision of this title with respect to any person is liable to such person in an amount equal to the sum of—

(1) any actual damage sustained by such person as a result of such failure;

(2) (A) in the case of any action by an individual, such additional damages as the court may allow, but not exceeding $1,000; or

(B) in the case of a class action,

(i) such amount for each named plaintiff as could be recovered under subparagraph (A), and

(ii) such amount as the court may allow for all other class members, without regard to a minimum individual recovery, not to exceed the lesser of $500,000 or 1 per centum of the net worth of the debt collector; and

(3) in the case of any successful action to enforce the foregoing liability, the costs of the action, together with a reasonable attorney's fee as determined by the court. On a finding by the court that an action under this section was brought in bad faith and for the purpose of harassment, the court may award to the defendant attorney's fees reasonable in relation to the work expended and costs.

(b) In determining the amount of liability in any action under subsection (a), the court shall consider, among other relevant factors—

(1) in any individual action under subsection (a)(2)(A), the frequency and persistence of noncompliance by the debt collector, the nature of such noncompliance, and the extent to which such noncompliance was intentional; or

(2) in any class action under subsection (a)(2)(B), the frequency and persistence of noncompliance by the debt collector, the nature of such noncompliance, the resources of the debt collector, the number of persons adversely affected, and the extent to which the debt collector's noncompliance was intentional.

(c) A debt collector may not be held liable in any action brought under this title if the debt collector shows by a preponderance of evidence that the violation was not intentional and resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid any such error.

(d) An action to enforce any liability created by this title may be brought in any appropriate United States district court without regard to the amount in controversy, or in any other court of competent jurisdiction, within one year from the date on which the violation occurs.

(e) No provision of this section imposing any liability shall apply to any act done or omitted in good faith in conformity with any advisory opinion of the Commission, notwithstanding that after such act or omission has occurred, such opinion is amended, rescinded, or determined by judicial or other authority to be invalid for any reason.

§ 814. Administrative enforcement

(a) Compliance with this title shall be enforced by the Commission, except to the extent that enforcement of the requirements imposed under this title is specifically committed to another agency under subsection (b). For purpose of the exercise by the Commission of its functions and powers under the Federal Trade Commission Act, a violation of this title shall be deemed an unfair or deceptive act or practice in violation of that Act. All of the functions and powers of the Commission under the Federal Trade Commission Act are available to the Commission to enforce compliance by any person with this title, irrespective of whether that person is engaged in commerce or meets any other jurisdictional tests in the Federal Trade Commission Act, including the power to enforce the provisions of this title in the same manner as if the violation had been a violation of a Federal Trade Commission trade regulation rule.

(b) Compliance with any requirements imposed under this title shall be enforced under—

(1) section 8 of the Federal Deposit Insurance Act, in the case of—

(A) national banks, and Federal branches and Federal agencies of foreign banks, by the Office of the Comptroller of the Currency;

(B) member banks of the Federal Reserve System (other than national banks), branches and agencies of foreign banks (other than Federal branches, Federal agencies, and insured State branches of foreign banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25(a) of the Federal Reserve Act, by the Board of Governors of the Federal Reserve System; and

(C) banks insured by the Federal Deposit Insurance Corporation (other than members of the Federal Reserve System) and insured State branches of foreign banks, by the Board of Directors of the Federal Deposit Insurance Corporation;

(2) section 8 of the Federal Deposit Insurance Act, by the Director of the Office of Thrift Supervision, in the case of a savings association the deposits of which are insured by the Federal Deposit Insurance Corporation;

(3) the Federal Credit Union Act, by the Administrator of the National Credit Union Administration with respect to any Federal credit union;

(4) the Acts to regulate commerce, by the Secretary of Transportation, with respect to all carriers subject to the jurisdiction of the Surface Transportation Board;

(5) the Federal Aviation Act of 1958, by the Secretary of Transportation with respect to any air carrier or any foreign air carrier subject to that Act; and

(6) the Packers and Stockyards Act, 1921 (except as provided in section 406 of that Act), by the Secretary of Agriculture with respect to any activities subject to that Act.

The terms used in paragraph (1) that are not defined in this title or otherwise defined in section 3(s) of the Federal Deposit Insurance Act (12 U.S.C. 1813(s)) shall have the meaning given to them in section 1(b) of the International Banking Act of 1978 (12 U.S.C. 3101).

(c) For the purpose of the exercise by any agency referred to in subsection (b) of its powers under any Act referred to in that subsection, a violation of any requirement imposed under this title shall be deemed to be a violation of a requirement imposed under that Act. In addition to its powers under any provision of law specifically referred to in subsection (b), each of the agencies referred to in that subsection may exercise, for the purpose of enforcing

compliance with any requirement imposed under this title any other authority conferred on it by law, except as provided in subsection (d).

(d) Neither the Commission nor any other agency referred to in subsection (b) may promulgate trade regulation rules or other regulations with respect to the collection of debts by debt collectors as defined in this title.

§ 815. Reports to Congress by the Commission

(a) Not later than one year after the effective date of this title and at one-year intervals thereafter, the Commission shall make reports to the Congress concerning the administration of its functions under this title, including such recommendations as the Commission deems necessary or appropriate. In addition, each report of the Commission shall include its assessment of the extent to which compliance with this title is being achieved and a summary of the enforcement actions taken by the Commission under section 814 of this title.

(b) In the exercise of its functions under this title, the Commission may obtain upon request the views of any other Federal agency which exercises enforcement functions under section 814 of this title.

§ 816. Relation to State laws

This title does not annul, alter, or affect, or exempt any person subject to the provisions of this title from complying with the laws of any State with respect to debt collection practices, except to the extent that those laws are inconsistent with any provision of this title, and then only to the extent of the inconsistency. For purposes of this section, a State law is not inconsistent with this title if the protection such law affords any consumer is greater than the protection provided by this title.

§ 817. Exemption for State regulation

The Commission shall by regulation exempt from the requirements of this title any class of debt collection practices within any State if the Commission determines that under the law of that State that class of debt collection practices is subject to requirements substantially similar to those imposed by this title, and that there is adequate provision for enforcement.

§ 818. Exception for certain bad check enforcement programs operated by private entities

(a) In General.—

(1) TREATMENT OF CERTAIN PRIVATE ENTITIES.—Subject to paragraph (2), a private entity shall be excluded from the definition of a debt collector, pursuant to the exception provided in section 803(6), with respect to the operation by the entity of a program described in paragraph (2)(A) under a contract described in paragraph (2)(B).

(2) CONDITIONS OF APPLICABILITY.—Paragraph (1) shall apply if—

(A) a State or district attorney establishes, within the jurisdiction of such State or district attorney and with respect to alleged bad check violations that do not involve a check described in subsection (b), a pretrial diversion program for alleged bad check offenders who agree to participate voluntarily in such program to avoid criminal prosecution;

(B) a private entity, that is subject to an administrative support services contract with a State or district attorney and operates under the direction, supervision, and control of

such State or district attorney, operates the pretrial diversion program described in subparagraph (A); and

(C) in the course of performing duties delegated to it by a State or district attorney under the contract, the private entity referred to in subparagraph (B)—

(i) complies with the penal laws of the State;

(ii) conforms with the terms of the contract and directives of the State or district attorney;

(iii) does not exercise independent prosecutorial discretion;

(iv) contacts any alleged offender referred to in subparagraph (A) for purposes of participating in a program referred to in such paragraph—

(I) only as a result of any determination by the State or district attorney that probable cause of a bad check violation under State penal law exists, and that contact with the alleged offender for purposes of participation in the program is appropriate; and

(II) the alleged offender has failed to pay the bad check after demand for payment, pursuant to State law, is made for payment of the check amount;

(v) includes as part of an initial written communication with an alleged offender a clear and conspicuous statement that—

(I) the alleged offender may dispute the validity of any alleged bad check violation;

(II) where the alleged offender knows, or has reasonable cause to believe, that the alleged bad check violation is the result of theft or forgery of the check, identity theft, or other fraud that is not the result of the conduct of the alleged offender, the alleged offender may file a crime report with the appropriate law enforcement agency; and

(III) if the alleged offender notifies the private entity or the district attorney in writing, not later than 30 days after being contacted for the first time pursuant to clause (iv), that there is a dispute pursuant to this subsection, before further restitution efforts are pursued, the district attorney or an employee of the district attorney authorized to make such a determination makes a determination that there is probable cause to believe that a crime has been committed; and

(vi) charges only fees in connection with services under the contract that have been authorized by the contract with the State or district attorney.

(b) Certain Checks Excluded.—A check is described in this subsection if the check involves, or is subsequently found to involve—

(1) a postdated check presented in connection with a payday loan, or other similar transaction, where the payee of the check knew that the issuer had insufficient funds at the time the check was made, drawn, or delivered;

(2) a stop payment order where the issuer acted in good faith and with reasonable cause in stopping payment on the check;

(3) a check dishonored because of an adjustment to the issuer's account by the financial institution holding such account without providing notice to the person at the time the check was made, drawn, or delivered;

(4) a check for partial payment of a debt where the payee had previously accepted partial payment for such debt;

(5) a check issued by a person who was not competent, or was not of legal age, to enter into a legal contractual obligation at the time the check was made, drawn, or delivered; or

(6) a check issued to pay an obligation arising from a transaction that was illegal in the jurisdiction of the State or district attorney at the time the check was made, drawn, or delivered.

(c) Definitions.—For purposes of this section, the following definitions shall apply:

(1) STATE OR DISTRICT ATTORNEY.—The term "State or district attorney" means the chief elected or appointed prosecuting attorney in a district, county (as defined in section 2 of title 1, United States Code), municipality, or comparable jurisdiction, including State attorneys general who act as chief elected or appointed prosecuting attorneys in a district, county (as so defined), municipality or comparable jurisdiction, who may be referred to by a variety of titles such as district attorneys, prosecuting attorneys, commonwealth's attorneys, solicitors, county attorneys, and state's attorneys, and who are responsible for the prosecution of State crimes and violations of jurisdiction-specific local ordinances.

(2) CHECK.—The term "check" has the same meaning as in section 3(6) of the Check Clearing for the 21st Century Act.

(3) BAD CHECK VIOLATION.—The term "bad check violation" means a violation of the applicable State criminal law relating to the writing of dishonored checks.

§ 819. Effective date

This title takes effect upon the expiration of six months after the date of its enactment, but section 809 shall apply only with respect to debts for which the initial attempt to collect occurs after such effective date.

Approved: _____ _____
Date

Approved: _____ _____
Date

Approved: _____ _____
Date

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Medicare Bad Debt Referrals

CATEGORY: Credit & Collection	Policy: Medicare Bad Debt Referrals
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To outline the procedure for referring Medicare deductible and coinsurance balances that are deemed to be uncollectible to Bad Debt.

I. POLICY

Medicare accounts with a patient liability for which payment cannot be obtained after reasonable follow-up efforts have been exhausted (set by hospital policy in conjunction with Federal, State, or payer specific regulations), will be transferred to bad debt status. These accounts shall further be referred to an outside collection agency for additional collection activities provided the Medicare 120-Day Bad Debt Rule has been followed. The goal is to ensure that accounts that are deemed uncollectible with outstanding patient balances are written off to bad debt.

II. PROCEDURE

Refer to the following steps when transferring Medicare accounts to bad debt:

1. Determine that the account meets the following criteria:
   - It has been *at least* 120 days since the first statement was generated subsequent to Medicare processing the claim, Medicare payment posted to account, and patient liability determined
   - Patient/guarantor has defaulted on an agreed installment arrangement
   - Guarantor has received the designated number of statements (at least three, unless account has been flagged as a 'Bad Address' subsequent to at least one statement being generated. *Ensure that account has not been placed on hold.*
2. If the above criteria have been met, transfer the patient's account to 'Bad Debt' in Cerner
3. Identify accounts that are not eligible for bad debt turnover
4. Document in comments the reason that account is not eligible for bad debt write-off, i.e. has not been 120 days since statement
5. Encounters will be referred to Bad Debt Collections in one of two ways:

   - ***Electronic:*** Encounters returned from NCO Outsourcing ***with*** cancel codes specific to bad debt, will be identified by the cancel code and routed automatically to one of the two collection agencies
     - Encounters with cancel code 81 will be routed to Connecticut Credit
     - Encounters with cancel code 84 will be routed to American Adjustment Bureau

- ***Manual:*** Encounters returned from NCO Outsourcing ***without*** cancel codes specific to bad debt, will be manually assigned to collections as necessary.
    - The manual assignment process is monitored and completed by the Reporting Analyst.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

CMS Reg - Medicare Bad Debt Guidelines

9-74 BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES 300

300. PRINCIPLE
Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable costs; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the Program.

302. DEFINITIONS

302.1 Bad Debts.--Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

302.2 Allowable Bad Debts.--Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 308. Allowable bad debts must relate to specific deductibles and coinsurance amounts.

302.3 Charity Allowances.--Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

302.4 Courtesy Allowances.--Courtesy Allowances are reductions in charges by the provider in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Reductions in charges made as employee fringe benefits, such as hospitalization and personnel health programs are not considered courtesy allowances.

302.5 Deductible and Coinsurance Amounts.--Deductible and coinsurance amounts are amounts payable by beneficiaries for covered services received from providers of services, excluding medical and surgical services rendered by physicians and surgeons. These deductibles and coinsurance amounts, including the blood deductible, must relate to inpatient hospital services, post-hospital extended care services, home health services, out-patient services, and medical and other health services furnished by a provider of services.

304. BAD DEBTS UNDER MEDICARE

Bad debts resulting from deductible and coinsurance amounts which are uncollectible from beneficiaries are not includable as such in the provider's allowable costs; however, unrecovered

costs attributable to such bad debts are considered in the Program's calculation of reimbursement to the provider.

The allowance of unrecovered costs attributable to such bad debts in the calculation of reimbursement by the Program results from the expressed intent of Congress that the costs of services covered by the Program will not be borne by individuals not covered, and the costs of services not covered by the Program will not be borne by the Program. Payment for deductibles and coinsurance amounts is the responsibility of the beneficiaries. However, the inability of the provider to collect deductibles and coinsurance amounts from beneficiaries of the Program could result in part of the costs of covered services being borne by others who are not beneficiaries of the Program. Therefore, to assure that costs of covered services are not borne by others because Medicare beneficiaries do not pay their deductibles and coinsurance amounts, the Medicare Program will reimburse the provider for allowable bad debts, not to exceed the total amount of unrecovered costs of covered services furnished to all beneficiaries. In the determination of unrecovered costs due to bad debts, the Medicare Program is considered as a whole without distinction between Part A and Part B of the Program.

305. EFFECT OF THE WAIVER OF LIABILITY PROVISION ON BAD DEBTS

A. Beneficiary Liability.--The waiver of liability provision of the law protects a beneficiary from liability for payments to a provider for noncovered services when (l) the services are found to be not reasonable and necessary or to involve custodial care (i.e., excluded from coverage under section l862(a)(l) or (9) of the Social Security Act), and (2) the beneficiary did not know or could not reasonably be expected to have known that the services were not covered. Where the beneficiary had knowledge that the services were not covered, liability will remain with the beneficiary.

B. Provider Not Accountable.--The program will reimburse the provider for the services if the provider did not know and could not reasonably be expected to have known that the services were not covered and the beneficiary had no knowledge as described n paragraph A. If the provider has such knowledge, it will assume accountability for the noncovered services. Where neither the provider nor the beneficiary is found accountable, the provider's charges for the services and the patient days are recorded as Medicare charges and Medicare patient days. The provider is entitled to collect from the beneficiary the amounts that would have represented the deductible and coinsurance amounts. If these amounts are not collected, they can be reimbursed under the Medicare bad debt provision (see 304) since the effect of the waiver of liability provision is to reimburse the provider as it would have been reimbursed had the services been covered.

C. Provider Accountable.--Where the provider is found accountable, any bad debts the provider experiences from such a program decision (i.e., those charges the provider cannot collect from the beneficiary) cannot be reimbursed under the Medicare bad debt provision as defined in §302. Provider costs attributable to these noncovered services furnished a beneficiary where the beneficiary's liability to the provider has been waived must be included in a provider's total costs for cost report purposes. The provider's charges for the services and the patient days must be shown as non-Medicare charges and non-Medicare patient days. The provider is nevertheless

entitled to collect from the beneficiary the amounts that would have represented the deductible and coinsurance amounts had the services been covered. If these amounts are not collected, however, they cannot be reimbursed under the Medicare bad debt provision since they apply to services held to be not covered. (See §306 below.)

306. BAD DEBTS RELATING TO NONCOVERED SERVICES OR TO NONBENEFICIARIES

If a beneficiary does not pay for services which are not covered by Medicare, the bad debts attributable to these services are not reimbursable under the Medicare program. Likewise, bad debts arising from services to non-Medicare patients are not reimbursable under the program.

Services which are not covered are defined generally in the following Health Insurance Manuals:

CMS-Pub. 10 Hospital Manual - §260
CMS-Pub. 11 Home Health Agency Manual - §§230 and 232
CMS-Pub. 12 Skilled Nursing Facility Manual - §240

308. CRITERIA FOR ALLOWABLE BAD DEBT

A debt must meet these criteria to be an allowable bad debt:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts. (See §305 for exception.)

2. The provider must be able to establish that reasonable collection efforts were made.

3. The debt was actually uncollectible when claimed as worthless.

4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

310. REASONABLE COLLECTION EFFORT

To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See §312 for indigent or medically indigent patients.)

A. Collection Agencies.--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. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

B. Documentation Required.--The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

310.1 Collection Fees.--Where a provider utilizes the services of a collection agency and the reasonable collection effort described in §310 is applied, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.

When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs. For example, where an agency collects $40 from the beneficiary, and its fee is 50 percent, the agency keeps $20 as its fee for the collection services and remits $20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency ($40) in the patient's account receivable and records the collection fee ($20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service, and, therefore, is not treated as a bad debt.

310.2 Presumption of Noncollectibility.--If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

312. INDIGENT OR MEDICALLY INDIGENT PATIENTS

In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:

A. The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;

B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

C. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; and

D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures. (See §322 for bad debts under State Welfare Programs.)

314. ACCOUNTING PERIOD FOR BAD DEBTS

Uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. Allowable bad debts must be related to specific amounts which have been determined to be uncollectible. Since bad debts are uncollectible accounts receivable and notes receivable, the provider should have the usual accounts receivable records-ledger cards and source documents to support its claim for a bad debt for each account included. Examples of the types of information to be retained may include, but are not limited to, the beneficiary's name and health insurance number; admission/discharge dates for Part A bills and dates of services for Part B bills; date of bills; date of write-off; and a breakdown of the uncollectible amount by deductible and coinsurance amounts. This proposed list is illustrative and not obligatory.

316. RECOVERY OF BAD DEBTS

Amounts included in allowable bad debts in a prior period might be recovered in a later reporting period. Treatment of such recoveries under the program is designed to achieve the same effect upon reimbursement as in the case where the amount was uncollectible.

Where the provider was reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are reduced by the amounts recovered. However, such reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period.

Where the provider was not reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are not reduced.

320. METHODS OF DETERMINING BAD DEBT EXPENSE

320.1 Direct Charge-Off.--Under the direct charge-off method, accounts receivable are analyzed and a determination made as to specific accounts which are deemed uncollectible. The amounts deemed to be uncollectible are charged to an expense account for uncollectible accounts. The amounts charged to the expense account for bad debts should be adequately identified as to those which represent deductible and coinsurance amounts applicable to beneficiaries and those which are applicable to other than beneficiaries or which are for other than covered services. Those bad debts which are applicable to beneficiaries for uncollectible deductible and coinsurance amounts are included in the calculation of reimbursable bad debts. (See §§300, 302.2, 314, and 316.)

320.2 Reserve Method.--Bad debt expenses computed by use of the reserve method are not allowable bad debts under the program. However, the specific uncollectible deductibles and coinsurance amounts applicable to beneficiaries and charged against the reserve are includable in the calculation of reimbursable bad debts. (See §308.)

Under the reserve method, providers estimate the amount of bad debts that will be incurred during a period, and establish a reserve account for that amount. The amount estimated as bad debts does not represent any particular debts, but is based on the aggregate of receivables or services.

322. MEDICARE BAD DEBTS UNDER STATE WELFARE PROGRAMS

Prior to 1968, title XIX State plans under the Federal medical assistance programs were required to pay the Part A deductible and coinsurance amounts for inpatient hospital services furnished through December 31, 1967. Any such deductible or coinsurance amounts not paid by the State were not allowable as a bad debt.

Effective with the 1967 Amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically or medically needy persons. For example, a State which covers hospital care for only 30 days for Medicaid recipients is not obligated (unless made part of the State title XIX plan) to pay all or part of the Medicare coinsurance from the 61st day on. For services that are within the scope of the title XIX plan, States continue to be obligated to pay the full deductible and coinsurance for categorically needy persons for most services, but can impose some cost sharing under the plan on medically needy persons as long as the amount paid is related to the individual's income or resources.

Where the State is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements of §312 or, if applicable, §310 are met.

In some instances, the State has an obligation to pay, but either does not pay anything or pays only part of the deductible or coinsurance because of a State payment "ceiling." For example, assume that a State pays a maximum of $42.50 per day for SNF services and the provider's cost is $60.00 a day. The coinsurance is $32.50 a day so that Medicare pays $27.50 ($60.00 less

$32.50). In this case, the State limits its payment towards the coinsurance to $15.00 ($42.50 less $27.50). In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of §312 are met.

If the State is not participating under title XIX, but State or local law requires the welfare agency to pay the deductible and coinsurance amounts, any such amounts are not includable in allowable bad debts. If neither the title XIX plan nor State or local law requires the welfare agency to pay the deductible and coinsurance amounts, there is no requirement that the State be responsible for these amounts. Therefore, any such amounts are includable in allowable bad debts provided that the requirements of §312 or, if applicable, §310 are met.

324. PROVIDER-BASED PHYSICIANS--PROFESSIONAL COMPONENT NOT A BAD DEBT

The professional component of a provider-based physician's remuneration is not recognized as an allowable bad debt in the event the provider is unable to collect the charges for the professional services of such physicians. Bad debts are recognized only if they relate to a provider's "allowable"
costs. "Allowable" costs pertain only to covered services for which the provider can bill on its own behalf under Part A and Part B. They do not pertain to costs of services the provider might bill on behalf of the provider-based physician. Technically, the professional component is a physician charge, not a provider cost. Thus, considering physician reimbursement as a provider cost in determining allowable bad debts would not be in conformance with the law.

326. APPLYING COLLECTIONS FROM BENEFICIARIES

When a beneficiary or a third party on behalf of the beneficiary makes a partial payment of an amount due the provider, which is not specifically identified as to which debt it is intended to satisfy, the payment is to be applied proportionately to Part A deductibles and coinsurance, Part B deductibles and coinsurance and noncovered services. The basis for proration of partial payments is the proportionate amount of amounts owed in each of the categories.

328. CHARITY, COURTESY, AND THIRD-PARTY PAYER ALLOWANCES--COST TREATMENT

Charity, courtesy, and third-party payer allowances are not reimbursable Medicare costs. Charges related to services subject to these allowances should be recorded at the full amount charged to all patients, and the allowances should be appropriately shown in a revenue reduction account. The amount reflecting full charges must then be used as applicable to apportion costs and in determining customary charges for application of the lower of costs or charges provision.

Example - The provider entered into an agreement with a third-party payer to render services at 25 percent below charges. Accordingly, for an X-ray service with a charge of $40, the provider billed the third party payer $30. The charge of $40 would be used to apportion costs and the $10 allowance would be recorded in a revenue reduction account.

331. CREDIT CARD COSTS

Reasonable charges made by credit card organizations to a provider are recognized as allowable administrative costs. Credit card charges incurred by a provider of services represent costs incurred for prompt collection of accounts receivable. These charges have come to be recognized as a substitute for the costs that would otherwise be incurred for credit administration (e.g., credit investigation and collection costs).

332. ALLOWANCE TO EMPLOYEES

Allowances, or reduction in charges, granted to employees for medical services as fringe benefits related to their employment are not considered courtesy allowances. Employee allowances are usually given under employee hospitalization and personnel health programs.

The allowances themselves are not costs since the costs of the services rendered are already included in the provider's costs. However, any costs of the services not recovered by the provider from the charge assessed the employee are allowable costs.

332.1 Method for Including Unrecovered Cost.--The unrecovered cost of services furnished to employees as fringe benefits may be included in allowable costs by treating the amount actually charged to the employees as a recovery of costs. Where the cost of the service exceeds the amount charged to the employee, the amount charged to the employee would be applied as a reduction in the costs of the particular department(s) rendering the services. If costs should be apportioned by the RCCAC Method, all charges related to employees' services would be subtracted from the total charges used to apportion such costs, so that unrecovered costs relating to employees' allowances would be apportioned between Medicare patients and other patients. Likewise, where an average cost per diem is used to apportion costs, the days applicable to the employees who received the allowances should be removed from the total days used to apportion costs.

Where the amount charged to an employee exceeds the costs of the services provided, there is no unrecovered cost and, therefore, no cost of fringe benefit. In this case, the amount charged to the employee is not offset against the department costs and the charges for the services given to the employee are not deleted from the total charges. The services furnished to employees are treated the same as services furnished to any other patients.

Approved: _____ _____
Date

Approved: _____ _____
Date

Approved: _____ _____
Date

Waterbury Hospital

POLICY AND PROCEDURES

Medicare Bad Debt Reporting Policy

CATEGORY: Credit & Collection	**Policy: Medicare Bad Debt Reporting**
REVIEWED:06/10	**REVISED: 06/10**
RETIRED:	**Comments:**

Purpose: To ensure that all outstanding Medicare deductible and coinsurance balances that are deemed to be uncollectible are reported via the cost report to Medicare for the previous fiscal year.

I. POLICY

In determining Medicare Bad Debt Accounts Waterbury Hospital will follow the regulations set forth in the Medicare Provider Reimbursement Manual and the Waterbury Hospital Dunning and Collecting from Medicare Patients Policy. Waterbury Hospital will report all uncollected Medicare deductible and coinsurance balances to Medicare on the Medicare Cost Report.

II. PROCEDURE

When deductible and coinsurance balances are deemed to be uncollectible these balances can be reported back to Medicare via the annual cost report as follows:

1. On October 1st of each year, a report is generated to reflect outstanding Medicare encounters that were turned over to bad debt in the previous fiscal year.
2. The encounters are broken down by inpatient and outpatient categories.
3. All Medicare bad debt encounters are reviewed based on the following criteria:
    a. Verification that the balance is either patient deductible or co-insurance
    b. All adjustments were processed
    c. Has any portion of the balance been paid by the patient or another insurance carrier.
    d. Has Medicare paid all that was expected

Once all Encounters are reviewed, the patient data for each Encounter is recorded on the Schedule of Medicare Reimbursable Bad Debts in accordance with the following instructions:

Column	Column Title	Description
I.	Provider Number	Patient's Medicare number
II	Patient Name	
III	Date of Admission	Date service started
IV	Date of Discharge	Date service ended
V	Total covered	Total Part A hospital charges

VI	Patient Deductible Amount	Part A Deductible
VII	Patient Co insurance Amount	Part A Co insurance
VIII	Bad Debt amount claimed	The balance of the Part A hospital charges that are still outstanding
IX	Date of write off	Date Encounter was sent to bad debt
X	Medicare remittance date	The date of the remittance that the NGS Medicare payment was processed

After all Encounters have been recorded on the schedule, the report is copied for audit purposes and the original is sent to the Finance Department. An electronic record should also be taken of all bad debt amounts claimed.

The report and schedule are maintained in the Finance Department until the next fiscal year.

Note: Medicare Bad Debts under Medicaid Programs
Effective with the 1967 Amendments, states no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the state title XIX program for either categorically or medically needy persons. Any portion of such deductible or coinsurance amounts that the state not obligated to pay can be included as bad debt under Medicare, provided that the requirements for determining indigent or medically indigent have been applied and met or if the patient meets other collection efforts.

III. AUDITING
The auditing process insures that balances reported to Medicare as bad debts have been appropriately dunned according to Medicare guidelines.

Audit process for Medicare co-pays and deductibles reported as bad debts on cost report

I. Internal auditor
1 Define the universe
- o Obtain the most recent filing
- o Determine the sample size and methodology

II. Assistant Director, Patient Accounts
1 Using the most recent filing:
- o Identify the sample Encounters
- o For each Encounter, pull all data from hospital HIS system and any adjunct system [OSI] to support Medicare Bad Debt policy guidelines
- o Send sample with attachments to internal auditor.

III. Internal Auditor
2 Review each Encounter against Medicare Bad Debt policy guidelines
3 Determine success/failure
4 Define methodology to expand sample based on failure percentage

WATERBURY HOSPITAL

POLICIES AND PROCEDURES

Quality Assurance (QA) Review Program

DESCRIPTION/OVERVIEW:
This procedure describes the Quality Assurance Review Process for the Billing Staff.

AREAS OF RESPONSIBILITY:
This procedure applies to PAFS Management and any additional areas responsible for reviewing the quality of billing efforts.

GUIDELINES:

1. The Assistant Director of Patient Accounting will complete a bi-weekly Quality Assurance (QA) review for each staff member on the quality expectations established by Patient Accounting leadership.

    - The QA Review process should take approximately 30 - 45 minutes (per biller) to conduct an audit of a biller's accounts and complete the QA Account Review Form.

    - The QA Review Process is used to evaluate whether or not the biller recorded productive responses to the "Five W's":
        i. **Who** the biller spoke to?
        ii. **What** was the phone number dialed? Or method of inquiry?
        iii. **Where** is the claim in the life cycle? Paid? Denied? In-process?
        iv. **When** is the expected pay/check release date?
        v. **Why**: Document why the claim is denied; the claim has not been adjudicated; there is a delay in payment; etc.

    - 'Worked Accounts' are considered Productive if they have the following characteristics:
        i. **Quality** data is in the account note
        ii. The note is **Readable** (for examples please refer to the Readability and Appropriateness of Action Examples document) to someone outside of PAFS
        iii. The **Appropriate Action** was taken to resolve or move the Account Forward

    - A biller's work is considered to **'Meet the Standard'** when:
        i. Their **Overall Documentation Score** from the QA Review is **between 89 - 93%**
        ii. They show a reasonable attempt to **work their Credits and Remits work lists**
        iii. The biller shows **adherence to Billing Schedule and Policy**

- A biller's work is considered to **'Exceed the Standard'** when they meet all of the following goals:
    i. Their **Overall Documentation Score** from the QA Review is **greater than 93%**
    ii. They show a reasonable attempt to **work their Credits and Remits work lists**
    iii. The biller shows **adherence to Billing Schedule and Policy**

OVERALL SCORE CALCULATION:

1. **The Overall Scores will be tallied using the following weighting system**:
    i. The **Documentation Score** will account for 70% of the Overall Score. To identify this score divide the total points awarded by 60 (total possible documentation score); the resulting percentage will then be multiplied by .7 resulting in a total score for this competency. (Max 70 Points)
    ii. The **Remits Worked** will account for 10% of the Overall Score. If the Assistant Director deems that you are keeping your credit balance work list current, ten (10) points will be awarded. If you are not keeping your credit balance work list current, you will not receive credit for this competency. (Max 10 Points)
    iii. The **Credits Worked** will account for 10% of the Overall Score. If the Assistant Director deems that you are keeping your remit balance work list current, ten (10) points will be awarded. If you are not keeping your credit balance work list current, you will not receive credit for this competency. (Max 10 Points)
    iv. The **Adherence to Billing Schedule and Policy** component will account for 10% of the Overall Score. If the Assistant Director deems that you are acting in accordance with the billing schedule and policy, ten (10) points will be awarded. If you are not adhering to the billing schedule and policy, you will not receive credit for this competency. (Max 10 Points)

- **Benefits of Positive Performance Ratings:** If a biller achieves an Overall QA Score greater than 93% they are considered to 'Exceed Expectations'. If they 'Exceed Expectations' for four (4) consecutive review periods the Assistant Director of PAFS will have the discretion to move the individual biller's QA Review to a monthly schedule. If the biller's rating falls below the 'Meets Expectations' rating while on a monthly schedule, the Assistant Director shall revert back to a bi-weekly QA Review of the biller's work.

ACCOUNT SELECTION:

1. Five accounts "worked" by the biller during the previous week will be selected for a Quality (QA) Review.

- To select and identify the random sample, the QA Reviewer should produce a credit, error and productivity report, which documents all of the credits and errors associated with an individual biller during the review period. This report should **not** be formatted or sorted to any particular order.
- The QA Reviewer should then divide the total number of credits by five (5). The QA Reviewer should also divide the total number of errors by five (5). For example, if a biller showed 50 credits during the review period then the QA Reviewer would divide the sample by five (5) which equals 10. The QA Reviewer would then go to the list of claims worked and sample the 1st, 10th, 20th, 30th, 40th claim worked during the review period.

PROCEDURE:

1. Open the Review Indicator documents
    a. Review Indicators will define categories and indicators of account review, criteria in which errors and omissions in documentation are quantified, and sources of information for review.
2. Review the Account for Appropriate Actions and Accuracy
    a. Open ProFit
    b. Document the following data points from the patient account selected for evaluation.
        i. Encounter Number
        ii. Account Balance
        iii. Bill Date
        iv. First Date Worked
        v. Last Date Worked
        vi. Number Times the Account was Worked
    c. The Assistant Director of Patient Accounting will review the patient accounting system notes and document the presence of the account note details on the QA Account Review Form. The Assistant Director of PAFS will document as many fields on the QA Review form as possible based upon the information obtained in the patient accounting system. The review should be detailed and provide a clear picture of the follow-up actions performed on the account. Look for the following quality check points:
        i. The presence of an account note (comment) in ProFit for the review period
        ii. An explanation of the next steps and/or payment information, and/or any other pertinent information from the inquiry.
        iii. Overall readability to someone outside PAFS
        iv. Determine if the claim was worked appropriately or elevated according to the appropriate protocol.

v. Enter comments in the section provided which explain in detail the reason why the QA Review assigned the score (1 thru 5) to the Overall Readability and Appropriateness of Actions.

3. When the QA Reviewer has completed reviewing and scoring all accounts, a Documentation Score for the staff member must be determined. To determine the Documentation Score, add up the Total Score for each account and divide by 60 (Maximum Score). Enter this amount in the Documentation Score field on the Evaluation Summary Form.
4. Document whether the staff member has been keeping their credit and remit balance work list current
5. Note any future development goals and potential training needs of the biller
6. When the QA Review Form is complete, the Assistant Director of Patient Accounting will meet with the Biller to review the results of the QA Review performed on their accounts.
    - This meeting is meant to provide the biller with feedback on their performance and also provide them instruction on how to improve upon their billing and follow up techniques.
7. At the conclusion of the Quality Review Meeting the Assistant Director of Patient Accounting will enter the Biller's Response and any additional meeting notes at the bottom of the QA Review Form.
8. Document the biller's response to the feedback and apply any additional comments from the Performance Review conversation.
9. The completed QA Review Form should then be filed in the biller's personnel file and may be used when conducting overall performance reviews at year end.

ATTACHMENTS:

1. Quality Review Worksheet
2. Review Indicators
3. Department Evaluation Summary Sheet

WATERBURY HOSPITAL HEALTH CENTER

POLICIES AND PROCEDURES

Quality Assurance (QA) Review Program: Review Indicators

PURPOSE:

The Waterbury Hospital Quality Assurance (QA) Program ***Review Indicators*** will serve as a resource for Waterbury Hospital Leadership and staff. Specifically, the Review Indicators will define the key elements of a quality account resolution inquiry and criteria in which errors / omissions in documentation are quantified.

REVIEW INDICATORS:

Review the patient accounting system notes and document the presence of the following elements in the account notes. Look for the following quality check points:

i. Is there a note (comment) on the encounter in ProFit for the review period? **(1 = Yes / 0 = No)**

ii. Is there a detailed explanation of the next steps, payment information (Amount / Pay Date), and/or any other pertinent information from the inquiry? **(1 = Yes / 0 = No)**

iii. What is the overall readability of the note to someone outside PAFS? Did the biller enter notes according to the detail and specifications in the Situation and Response Guide? **(Score 1, 3 or 5)**

iv. Determine if the claim was worked appropriately and/or took the appropriate actions on the claim. Did the biller take the appropriate actions as specified in the Situation and Response Guide? For example, did the biller escalate the account to the correct department for follow up? **(Score 1, 3 or 5)**

v. The reviewer should then enter notes in the Comments field which explain in detail the reason why the QA Review assigned the score (1, 3 or 5) to the Overall Readability and Appropriateness of Actions. The QA Reviewer should provide clarification as to how the reviewed biller can receive a five (5) as the QA Review is intended to be a training tool in addition to an evaluation tool.

Waterbury Hospital

POLICY AND PROCEDURES

Billing Quality Assurance

Purpose: To ensure that billing is done accurately and in a timely fashion, while maintaining levels of quality.

I. POLICY

In order to maintain levels of quality in billing, clean claim rates and billing edits will be reviewed on a daily and weekly basis by the Assistant Director, PAFS. The goal for Initial Clean Claim Pass Rate is 90%, while the goal for Final (After Correction) Clean Claim Pass Rate is 99%.

II. PROCEDURE

Clean Claim Pass Rate

- The Clean Claim Database is the primary tool to monitor the Clean Claim Pass Rate goals.
    1. The Clean claim database is updated on a daily basis by Department Assistant, ensuring the most accurate and up-to-date reporting on clean claim rates.
    2. Clean claim information is obtained from daily billing tracking documentation provided by SSI and the manual tallies from the PC-Ace (Blue Cross) in the billing office.
    3. Claim volume, claims translated, claims scrubbed for all SSI, Blue Cross and Blue Cross Family Plan are reported and trended daily and weekly.

Billing Edits

- The Billing Edits Workgroup is a weekly review of Billing Edits by the Assistant Director of Patient Accounts and the Billing staff.
    1. Daily billing edits are input into the database by the Department Assistant. Complete detailed descriptions, as well as frequency, are put into the database. Billing edit reporting is generated from the data.
    2. Billing edit reports are used in identifying trends in edits during weekly workgroup meetings.
    3. Edits are documented and reviewed by Assistant Director and appropriate billing staff on a weekly basis.

4. This meeting will review root causes of edits, provide follow up actions to reduce the occurrence of edits (if applicable), assign responsibility and identify any issue the staff may be observing.

Productivity Metrics

- Productivity Metrics are used to monitor the daily workload of the staff and ensure all bills are released daily.
- Assistant Director to monitor daily productivity and billing volumes by running the Total Billed report and the SSI Claim Pass Rate chart in the Clean Claim Database
- Ensure all bills are submitted timely through review of DNFB and Clean Claim reports
- Monitor CRE and SSI Hold Reports to ensure no claims are held unnecessarily

If quality and productivity metrics are not met by the staff it is the responsibility of the Assistant Director of PAFS to perform corrective action

WATERBURY HOSPITAL

POLICIES AND PROCEDURES

Quality Assurance (QA) Review Program

DESCRIPTION/OVERVIEW:
This procedure describes the Quality Assurance Review Process for the Collection Representatives.

AREAS OF RESPONSIBILITY:
This procedure applies to PAFS Management and any additional areas responsible for reviewing the quality of staff collection and account follow-up efforts.

GUIDELINES:

1. The Assistant Director of Patient Accounting will complete a bi-weekly Quality Assurance (QA) review for each staff member on the quality expectations established by Patient Accounting leadership.

    - The QA Review process should take approximately 30 - 45 minutes (per collector) to conduct an audit of a collector's accounts and complete the QA Account Review Form.

    - The QA Review Process is used to evaluate whether or not the collector recorded productive responses to the "Five W's":
        i. **Who** the collector spoke to?
        ii. **What** was the phone number dialed? Or method of inquiry?
        iii. **Where** is the claim in the life cycle? Paid? Denied? In-process?
        iv. **When** is the expected pay/check release date?
        v. **Why**: Document why the claim is denied; the claim has not been adjudicated; there is a delay in payment; etc.

    - 'Worked Accounts' are considered Productive if they have the following characteristics:
        i. **Quality** data is in the account note
        ii. The note is **Readable** (for examples please refer to the Readability and Appropriateness of Action Examples document) to someone outside of PAFS
        iii. The **Appropriate Action** was taken to resolve or move the Account Forward

    - A collector's work is considered to **'Meet the Standard'** when:
        i. Their **Overall Documentation Score** from the QA Review is **greater than or equal to 85%**
        ii. They work (on average) greater than **35 Accounts per Day** during the review period.

iii. Their **Percent of Accounts Over 90 Days** is **less than or equal to 20%**
iv. They show a reasonable attempt to **keep their Work Queue(s) Current** and work through their book of active accounts within a reasonable time frame
v. They show a reasonable attempt to **work their Credit Work List** and keep the volume of accounts current

- A collector's work is considered to **'Exceed the Standard'** when they meet all four of the following goals:
  i. Their **Overall Documentation Score** from the QA Review is **greater than or equal to 90%**
  ii. They work (on average) more than **50 Accounts per Day** during the review period.
  iii. Their **Percent of Accounts Over 90 Days** is **less than or equal to 15%**
  iv. They show a reasonable attempt to **keep their Work Queue(s) Current** and work through their book of active accounts within a reasonable time frame
  v. They show a reasonable attempt to **work their Credit Work List** and keep the volume of accounts current

OVERALL SCORE CALCULATION:

1. **The Overall Scores will be tallied using the following weighting system**:
   i. The **Documentation Score** will account for 60% of the Overall Score. To identify this score divide the total points awarded by 75 (total possible documentation score); the resulting percentage will then be multiplied by .6 resulting in a total score for this competency. (Max 60 Points)
   ii. The **Average Number of Accounts Worked** will account for 10% of the Overall Score. If 50 or more accounts are worked ten (10) points will be awarded. If 35 to 50 accounts are worked five (5) points will be awarded. If you work less than 35 accounts per week you will not receive credit for this competency. (Max 10 Points)
   iii. The **Average Percent of Accounts Over 90 Days** will account for 10% of the Overall Score. If the percent of accounts over 90 days is less than or equal to 15% ten (10) points will be awarded. If the percent of accounts over 90 days is between 15% and 20% five (5) points will be awarded. If the percent of accounts over 90 days is greater than 20% you will not receive credit for this competency. (Max 10 Points)
   iv. **Keeping your Work Queues Current** will account for 10% of the Overall Score. If the Assistant Director deems that you are working through your book of active accounts within a reasonable

time frame ten (10) points will be awarded. If you are not working accounts in a meaningful time frame you will not receive credit for this competency. (Max 10 Points)

v. **Working your Credit Balance Work List** will account for 10% of the Overall Score. If the Assistant Director deems that you are keeping your credit balance work list current ten (10) points will be awarded. If you are not keeping your credit balance work list current you will not receive credit for this competency. (Max 10 Points)

- **Benefits of Positive Performance Ratings:** If a collector achieves an Overall QA Score greater than 90% they are considered to 'Exceed Expectations'. If they 'Exceed Expectations' for four (4) consecutive review periods the Assistant Director of PAFS will have the discretion to move the individual collector's QA Review to a monthly schedule. If the collector's rating fall below the 'Meets Expectations' rating while on a monthly schedule the Assistant Director shall revert back to a bi-weekly QA Review of the collector's work.

ACCOUNT SELECTION:

1. Five accounts "worked" by the collector during the previous week will be selected for a Quality (QA) Review.

    - To select and identify the random sample the QA Reviewer should produce a productivity report which documents all of the claims worked by an individual collector during the review period. This report should **not** be formatted or sorted to any particular order.
    - The QA Review should then divide the total number of accounts worked by five (5). For example if a collector worked 255 claims during the review period then the QA Reviewer would divide the sample by five (5) which equals 51. The QA Reviewer would then go to the list of claims worked and sample the 1st, 51st, 102nd, 153rd, 204th claim worked during the review period.

PROCEDURE:

1. Open the Review Indicator documents
    a. Review Indicators will define categories and indicators of account review, criteria in which errors and omissions in documentation are quantified, and sources of information for review.
2. Review the Account for Appropriate Actions and Accuracy
    a. Open ProFit
    b. Document the following data points from the patient account selected for evaluation.
        i. Encounter Number

ii. Account Balance
iii. Bill Date
iv. First Date Worked
v. Last Date Worked
vi. Number Times the Account was Worked

c. The Assistant Director of Patient Accounting will review the patient accounting system notes and document the presence of the account note details on the QA Account Review Form. The Assistant Director of PAFS will document as many fields on the QA Review form as possible based upon the information obtained in the patient accounting system. The review, similar to the collection process, should be detailed and provide a clear picture of the follow-up / collections actions performed on the account. Look for the following quality check points:
    i. The presence of an account note (comment) in ProFit for the review period
    ii. The payer representative's name
    iii. The method of the inquiry results (e.g., payer system, web-based tool or phone number dialed)
    iv. The claim status (i.e., Paid, In-Process, Pending, Denied, In-Review, Corrected, Other)
    v. An explanation of the next steps and/or payment information, and/or any other pertinent information from the inquiry.
    vi. Overall readability to someone outside PAFS
    vii. Determine if the claim was worked appropriately or elevated according to the appropriate protocol for accounts aged more than 90 days or if the claim was submitted to the Payer more than twice.
    viii. Enter comments in the section provided which explain in detail the reason why the QA Review assigned the score (1 thru 5) to the Overall Readability and Appropriateness of Actions.

3. When the QA Reviewer has completed reviewing and scoring all accounts, a Documentation Score for the staff member must be determined. To determine the Documentation Score, add up the Total Score for each account and divide by 75 (Maximum Score). Enter this amount in the Documentation Score field on the Evaluation Summary Form.
4. Enter the Average Number of Accounts Worked Per Day from the Weekly Productivity Report for the review period
5. Enter the Percent of Accounts Over 90 Days from the Account Status Summary Report
6. Document whether the staff member has been keeping their work queues current and maintaining productivity relative to their 'Total Book of Business'
7. Document whether the staff member has been keeping their credit balance work list current
8. Note any future development goals and potential training needs of the collector
9. When the QA Review Form is complete the Assistant Director of Patient Accounting will meet with the Collector to review the results of the QA Review performed on their accounts.

- This meeting is meant to provide the collector with feedback on their performance and also provide them instruction on how to improve upon their account follow-up and collection techniques.

10. At the conclusion of the Quality Review Meeting the Assistant Director of Patient Accounting will enter the Collector's Response and any additional meeting notes at the bottom of the QA Review Form.
11. Document the collector's response to the feedback and apply any additional comments from the Performance Review conversation.
12. The completed QA Review Form should then be filed in the collector's personnel file and may be used when conducting overall performance reviews at year end.

ATTACHMENTS:

1. Quality Review Worksheet
2. Individuation Evaluation Summary Sheet
3. Review Indicators
4. Readability and Appropriateness of Action Examples
5. Department Evaluation Summary Sheet

WATERBURY HOSPITAL HEALTH CENTER

POLICIES AND PROCEDURES

Quality Assurance (QA) Review Program: Review Indicators

PURPOSE:

The Waterbury Hospital Quality Assurance (QA) Program ***Review Indicators*** will serve as a resource for Waterbury Hospital Leadership and staff. Specifically, the Review Indicators will define the key elements of a quality account resolution inquiry and criteria in which errors / omissions in documentation are quantified.

REVIEW INDICATORS:

Review the patient accounting system notes and document the presence of the following elements in the account notes. Look for the following quality check points:

i. Is there a note (comment) on the encounter in ProFit for the review period? **(1 = Yes / 0 = No)**

ii. Has the payer representative's name been recorded in the note? **(1 = Yes / 0 = No)**

iii. Has the method of the inquiry been recorded in the note? (i.e., payer system, web-based tool or phone number dialled) **(1 = Yes / 0 = No)**

iv. Has the claim status been documented? (i.e., Paid, In-Process, Pending, Denied, In-Review, Corrected, Other) **(1 = Yes / 0 = No)**

v. Is there a detailed explanation of the next steps, payment information (Amount / Pay Date), and/or any other pertinent information from the inquiry? **(1 = Yes / 0 = No)**

vi. What is the overall readability of the note to someone outside PAFS? Did the collector enter notes according to the detail and specifications in the Situation and Response Guide? **(Score 1, 3 or 5)**

vii. Determine if the claim was worked appropriately and/or took the appropriate actions on the claim. Did the collector take the appropriate actions as specified in the Situation and Response Guide? For example, did the collector escalate the account according to the appropriate protocol for accounts aged more than 90 days or claims submitted to the Payer more than twice? **(Score 1, 3 or 5)**

viii. The reviewer should then enter notes in the Comments field which explain in detail the reason why the QA Review assigned the score (1, 3 or 5) to the Overall Readability and Appropriateness of Actions. The QA Reviewer should provide clarification as to how the reviewed collector can receive a five (5) as the QA Review is intended to be a training tool in addition to an evaluation tool.

WATERBURY HOSPITAL HEALTH CENTER

POLICIES AND PROCEDURES

Quality Assurance (QA) Review Program: Industry Standards

PURPOSE:

The Waterbury Hospital Quality Assurance (QA) Program ***Industry Standards*** Document will serve as a resource for Waterbury Hospital Leadership and staff. Specifically, the Best Practices Document will frame examples of a quality account resolution inquiry and criteria in which errors / omissions in documentation are qualified.

BEST PRACTICE EXAMPLES:

1) Best Practice Note:

1. Wrkg Work Queue; per payer website; clm # 123456 rcvd 6/1/09; status pending; f/u 15 days if no remit received

2. Wrkg Remit; Claim denied by payer; printed claim and mailed to mental health carrier; Payer Name @ PO Box 123, Waterbury, CT 06708

3. Wrkg Work Queue; per payer website; claim paid; $100 balance is patient resp; deductible assigned to OSI

4. Wrkg Work Queue; MC inquiry; 137 adjusted claim for $2000 is pending in location ; f/u 7 days if no remit received

2) Unsatisfactory Note:

1. Payer inquiry; claim in process

What is missing:

- **Who** the collector spoke to? **How** the collector received the claim?
- **What** was the phone number dialed? Or method of inquiry?
- **Where** is the claim in the life cycle? Paid? Denied? In-process?
- **When** is the expected pay/check release date? Be sure to **Note** the Next steps
- **Why**: Document why the claim is denied; the claim has not been adjudicated; there is a delay in payment; etc.

2. Payer x/fed IP ded for $xx.xx to eds & part b co-ins $xx.xx; waiting for payment

What is missing:

- **Who** the collector spoke to? **How** the collector received the claim?
- **What** was the phone number dialed? Or method of inquiry?
- **When** is the expected pay/check release date? Be sure to **Note** the Next steps
- **Why**: Document why the claim is denied; the claim has not been adjudicated; there is a delay in payment; etc.

3) Zero Credit Note:

1. ----------

What is missing:

- **Each one of the 5 W's is missing: Remember, if the action is not documented, it did not occur!**

Waterbury Hospital FY 09/10

UNINSURED STATUS
Patients at or below 200% of the FPIG, and who meet other criteria are eligible for a reduction of their bill to zero.

SLIDING SCALE DISCOUNT
Self Pay Patients whose income is above 200% of the poverty income guidelines, Level 1 thru Level 5

Self Pay patients whose income is beyond Level 5 do not qualify for a discount

2009 - 2010 Federal Poverty Income Guidelines	FAMILY SIZE	Income is between 0 and 200%	Level1	Level 2	Level 3	Level 4	Level 5
100%		100%	65%	55%	45%	35%	25%
$ 10,830	1	$ 21,660	$ 27,075	$ 38,075	$ 49,075	$ 60,075	$ 71,075
$ 14,750	2	$ 29,500	$ 36,875	47,875	58,875	69,875	80,875
$ 18,310	3	$ 36,620	$ 45,775	56,775	67,775	78,775	89,775
$ 22,050	4	$ 44,100	$ 55,125	66,125	77,125	88,125	99,125
$ 25,790	5	$ 51,580	$ 64,475	75,475	86,475	97,475	108,475
$ 29,530	6	$ 59,060	$ 73,825	84,825	95,825	106,825	117,825
$ 33,270	7	$ 66,540	$ 83,175	94,175	105,175	116,175	127,175
$ 37,010	8	$ 74,020	$ 92,525	103,525	114,525	125,525	136,525
$ 3,740	For each additional family member add	$ 7,480					

WATERBURY HOSPITAL
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PATIENT ACCESS / FINANCIAL SERVICES

Credit and Collection Policies
Free Care Manual
Patient Statement Handbook

2009-2010

WATERBURY HOSPITAL PATIENT ACCOUNTING FINANCIAL SERVICES (PAFS)
SCOPE OF SERVICE

OVERVIEW

The credit and collection policies in this manual cover the life cycle of the Accounts Receivable Management Process. It is the intent of these policies to fully inform all patients and staff, of the expectations of Waterbury Hospital for Encounter resolution. Waterbury Hospital will not deny necessary medical services due to insufficient financial resources, however, will inform and assist patients in pursuing financial assistance based on established regulations, criteria and available programs.

Policies governing certain aspects of Credit & Collection are also available in the Administrative Policies Manual.

Waterbury Hospital

Patient Accounting /Financial Services (PAFS) Department Scope of Service

Hospital Vision: The Greater Waterbury Health Network will be the healthcare organization of choice by providing superior service to patients and physicians.

Hospital Mission: The Greater Waterbury Health Network provides compassionate high quality health care through a family of professionals and services.

PAFS Department Vision: The Patient Accounting Financial Services Department will be dynamic and innovative in utilizing state of the art technology to achieve customer loyalty and fiscal viability. Waterbury Hospital will be recognized nationally as the benchmark for days outstanding and the management of Accounts Receivable.

The Patient Accounting Financial Services Department provides the following services for all in-patients and selected outpatients:

Central Scheduling / Registration

- Scheduling of elective services to include pre-admission testing
- Insurance Verification
- Registration of walk-in outpatients
- Point of Service collection

Emergency Room Registration

- ED Quick registration
- Bedside registration
- Point of Service collection
- Discharge Office
- Bed Control on off shifts

Support Services

- Electronic and hardcopy billing
- Encounter analysis
- Remittance analysis
- Encounter follow-up
- Encounter resolution

Customer Service / Financial Counseling

- Inpatient Discharge review
- Billing Inquiries via phone & walk-in
- Patient Assistance case presentation

System Support / Education

- ERM, ESM, EEM application support
- Profit support
- Process flow
- Training / Education for PAFS staff

Cash and allowance posting and reconciliation

- Payment and allowance posting
- Daily deposit
- Remittance Uploading
- Cashiering

All staff are required to have a thorough knowledge of the Cerner HIS system [Registration, Patient Encounters, HIM] as it relates to their particular area of expertise, as well as other related applications, systems and technologies. In addition, familiarity with State and Federal regulations, Third-Party requirements, and associated policies and procedures is required.

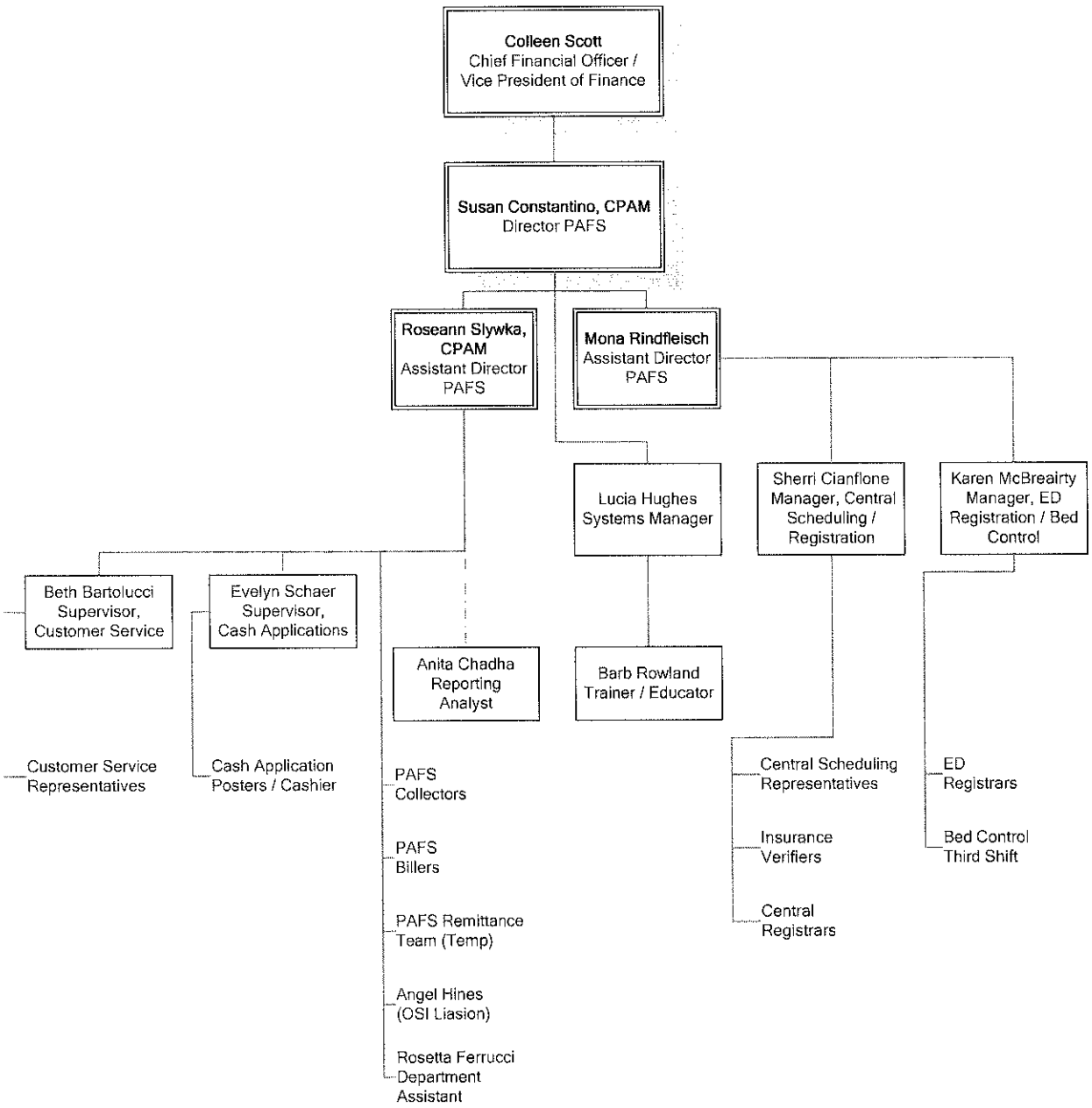
HOURS OF OPERATION:

Emergency Department – 24 hours per day, seven days per week
Central Scheduling/Registration – Monday through Friday, 6:00am – 6:00pm
Support Services – Monday through Friday, 8:00am – 4:30pm
Customer Service –Monday through Friday 8:00am – 4:30pm
Customer Service Phone Lines - Monday through Friday 8:30am - 3:30pm
OSI Outsourcing Phone Lines - Monday through Friday 8:00am – 5:00pm

Disclaimer:

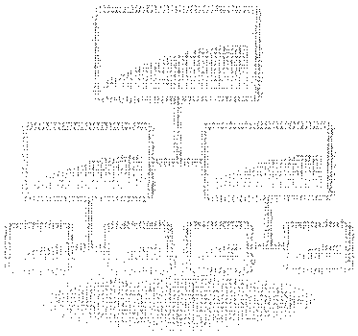
The information in the Patient Accounting Financial Services Department Scope of Service section has been designed to indicate the general nature and level of work performed by employees within the department. It is not designed to contain or be interpreted as a comprehensive inventory of all duties, responsibilities, and qualifications required of employees assigned to this department.

Patient Accounting Financial Services
Organizational Chart



PATIENT ACCESS / FINANCIAL SERVICES

ORGANIZATIONAL CHART FY10



Vice-President, Finance

Director, PAFS

PATIENT ACCOUNTS	CENTRAL REG/SCHED
Asst Director, Patient Accounts	Asst Director, Patient Access
Supervisor, Customer Service	Manager, Central Reg/Sched
Supervisor, Cash Applications	Manager, ED Registration

PAFS Manager, System Support
Application Support
Education / Training
Reporting/Analysis

Waterbury Hospital
CREDIT & COLLECTION MANUAL
2010

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Waterbury Hospital
CREDIT & COLLECTION POLICIES

PAFS - Billing

CATEGORY: Credit & Collection	POLICY: PAFS Billing
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To outline the steps required prior to and at the time of third-party billing.

I. POLICY

It is the policy of Waterbury Hospital Health Center to prepare claims according to established third party and internal guidelines. Waterbury will bill all claims daily with the exception of those claims awaiting follow up responses from the departments. It is the responsibility of the departments to respond to billing requests within 24 hours.

II. PROCEDURE

At time of discharge, the benefit order status is Ready to Bill. When an encounter is in Ready to Bill status, it is held for a minimum number of days depending on category before the system tries to bill the encounter. The following is the minimum number of days encounters are held in standard delay:

- Inpatient: 3 days after discharge
- Outpatient: 6 days after discharge

THE PURPOSE OF HOLDING ENCOUNTERS IN "STANDARD DELAY" IS TO ALLOW TIME TO PERFORM THE FOLLOWING FUNCTIONS:

- HIM coding
- Charge entry [charges can be posted at any time along the cycle]
- Satisfy compliance checks such as IP/OP overlaps, etc.
- Changes to information prior to final bill

Once the minimum number of days has been satisfied and all necessary functions are performed, the encounter is ready to bill. There are numerous edits built into the system to catch problem areas such as missing demographic and diagnosis, missing authorizations, etc. If an encounter cannot bill due to an edit, it will appears on the Corrections Requiring Edit (CRE) report. This report is distributed to users on a weekly basis. Once all edits are resolved, the claims are regenerated. When the encounter is final-billed, the claim status changes to Submitted.

Once submitted the claims are routed to one of two electronic billing platforms; SSI Click-on Billing or PCAce

- The following carriers are electronically scrubbed and billed via the SSI Click-On Claim Module in HIPAA-compliant format:
    - Medicare Part A - hospital
        - Compliance to various Medicare requirements regarding IP/OP overlapping bills, Non-Coverage letters, Medicare Secondary Payer questionnaire etc.
    - Medicare Part B - physician fees [First Coast]
    - Commercial and Managed Care payers - various large commercial payers
    - Medicaid - traditional

- The following carriers are electronically scrubbed and billed via the PCAce Module in HIPAA-compliant format:
    - Anthem Blue Cross.

The following claim forms are utilized.
UB04 - UNIFORM BILL-2004 The UB04 is the universal healthcare form accepted by all carriers for hospital inpatient and outpatient billing.

HCFA 1500 - The HCFA 1500 is the universal healthcare form accepted by all carriers for professional charge billing by hospitals and physician offices. Hardcopy claims are also produced for each electronic bill and for all other third parties, which are mailed directly to the carriers.

PAYER EDIT PROCESS
Claims will need to pass EXTENSIVE EDITS when they reach the third-party. Claims are rejected or pended based on carrier, until the problem is resolved.

When ALL EDITS/PROBLEMS have been resolved, the claim is accepted by the carrier for adjudication.

Support services staff utilizes follow-up reports for encounter analysis. It is not uncommon for third-parties to NOT receive a claim for various reasons. Many encounters have no payment or denial ever received. These encounters are worked based on high dollar.

Reference the Billing Situation and Response Guidelines for detailed instruction on resolving billing issues and edits.

Once an encounter is billed to the third-party, the encounter remains in AR status until it is resolved by payment or turned over to an outside collection agency.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Billing Edits

CATEGORY: Credit & Collection	**POLICY: PAFS Billing Edits**
REVIEWED:06/10	**REVISED: 06/10**
RETIRED:	**Comments:**

Purpose: To define a process for SSI and PC-Ace billing edit maintenance and review; To complete billing in a timely manner, inputting data necessary for tracking and summarization. Tracking edit data is vital for depicting the errors that are affecting billing accuracy.

I. POLICY

It is the policy of Waterbury Hospital Health Center to continually track and monitor the SSI and PC-Ace billing edits. Edits and errors will be tracked and reviewed daily. Review will include the resolution of SSI and PC-Ace billing edits issues.

II. PROCEDURE

Support services staff will pull in and review SSI and PC-Ace billing edits on a daily basis. Edit data will be input into the Clean Claim Pass Rate database. [See associated policies]

Edit data is reviewed for top edits creating the biggest impact on accurate and efficient billing. Billing Issues Log is owned and maintained by Assistant Director, PAFS. Billing Issues Log is used as direction in bi-weekly billing edits workgroup meeting.

Weekly workgroup meetings include billing staff (both SSI and PC-Ace) and Assistant Director, PAFS. Bi-weekly meetings will include the review of top edits and new edits creating problems for billing staff. Resolutions will be met in a timely manner.

Waterbury Hospital

CREDIT & COLLECTION MANUAL

Billing for Sexual Evidence Collection Kits & Associated Services

CATEGORY: Credit & Collection	POLICY: Billing for Sexual Evidence Collection Kits & Associated Services
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To define a process for identification of patients who are treated for sexual assault and subsequent billing of specific items/services to the Chief State's Attorney Office [CSA]; To obtain reimbursement from the state of Connecticut for these patients for the defined services and to comply with state regulations.

I. POLICY

It is the policy of Waterbury Hospital Health Center to identify sexual assault victims for purposes of appropriate billing as per state of Connecticut regulations.

II. PROCEDURE

Interim Process Effective September 26, 2003:
Billing requirements for the collection of evidence of a sexual assault were recently changed and the following services must be billed to the CSA

- Sexual assault evidence collection kit
- Testing for pregnancy
- Testing for sexually transmitted diseases
- Certain prophylactic treatment

These services must NOT be billed to the patient either directly or indirectly.

As of September 26, 2003, the CSA has not yet delineated exactly which prophylactic services should be billed to the state, however, at this time, hospitals are requested to submit the entire bill to the CSA for payment and not bill the patient for any part of an encounter when sexual assault evidence is collected. Bills should be forwarded to the attention of:

Director of Financial Services
Office of the Chief State's Attorney
300 Corporate Place
Rocky Hill, CT 06067

Patient Identification

- Nursing staff will notify the Manager, ED Registration of any patient who is treated for sexual assault and for which the above services are being performed.
    - In the absence of the Manger, ED Registration, notify the following:
        - Manager, Support Services, x7142
        - Director, PAFS, x7189
- The Manager, ED Registration will place a pre-bill hold on the encounter
- These encounters will appear on the Billing Entity Holds Report and will be reviewed by the Assistant Director, PAFS for appropriate billing to the CSA.
- Once the encounter is billed to the CSA, a general "H" hold will be placed on the encounter and monitored by the Assistant Director, PAFS for payment

This process will be updated when new billing and review procedures are received from the CSA.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Accounts Receivable Reporting

CATEGORY: Credit & Collection	**Policy: Accounts Receivable Reporting**
REVIEWED:06/10	**REVISED: 06/10**
RETIRED:	**Comments:**

Purpose: ***To provide the Director and Assistant Director of Patient Accounting a reporting mechanism for the purpose of identifying Patient Accounting performance trends and to ensure the constant and consistent reviews of the top unbilled and active receivable accounts.***

I. POLICY

The following reports are to be produced and distributed on a weekly basis by the Reporting Analyst for the Director and Assistant Director of PAFS, and CFO as necessary. The A/R Reports should be reviewed weekly by PAFS leadership to assist with the management and identification of Past Due accounts (i.e., accounts aging longer than expected) and the qualification of unbilled encounters.

Accounts Receivable Reports:

1.Encounter Detail ATB - Weekly
- This report will serve as the master Aging Report and will list the hospital's active receivable by encounter in ProFit regardless of discharge date.

2. A/R Aging by Financial Class by Aging Bucket
- This report will list the hospital's active receivable by Financial Class by Aging Category in ProFit regardless of discharge date.
- This report will act as a feeder to the A/R Tracking Report

3. A/R Aging by Financial Class by Aging Bucket Tracking Report
- This report will document Aging Trends by Financial Class.

4. Percent of A/R Aged Greater than 60 Days from Discharge
- This report will show Aging Trends for accounts aged more than 60 days by Financial Class.

5. Credit Balance Report
- This report will list the hospital's credit balance accounts and should be used to create credit balance worklists for the collections staff.

6. Daily DNFB Reports
- This report will be used to track and monitor the hospital's daily coding progress.

7. Top 100 Reports

- These reports will be used to track and monitor the hospital's high balance accounts in descending order:

1) Top 100 A/R - Total
   - This report will list the top 100 accounts by visit balance for accounts that have an A/R status of 'Active' in ProFit regardless of discharge date.

A. Top In-house/Unbilled Accounts
   i. This subset of the Top 100 Report will list the top accounts by visit balance for accounts that have an A/R status of 'In-house' or 'Unbilled' in ProFit.

B. Top A/R < 30 Days
   i. This subset of the Top 100 Report will list the top accounts by visit balance for accounts that have an A/R status of 'Active' in ProFit and have a discharge date < 30 days in the past.

C. Top A/R > 30 days
   i. This subset of the Top 100 Report will list the top accounts by visit balance for accounts that have an A/R status of 'Active' in ProFit and have a discharge date > 30 days in the past.

II. PROCEDURE

1. As needed, payers and/or patient A/R should be analyzed, reported and exported into Excel or Access, for further review.

2. To ensure timely resolution of patient accounts the Director and Assistant Director of PAFS will schedule monthly staff meetings with PAFS collectors (Medicare, Medicaid, Commercial, BCBS, Worker's Compensation and MVA), R&B, WHAP and other vendors as necessary to review the hospital's active receivable and specific patient accounts as needed.

3. Following these meeting the Director and Assistant Director will communicate trends/outstanding issues to the CFO and Steering Committee.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Collection of Medicare Self Pay after Insurance

CATEGORY: Credit & Collection	Policy: Collection of Medicare Self Pay after Insurance
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To comply with Medicare rules and regulations regarding reasonable and customary attempts to collect a bill from a Medicare patient [deductibles and co-payments].

I. POLICY

Medicare requires a reasonable collection effort consistent with how other self-pay patients are handled. Per the Provider Reimbursement Manual, section 310.2, "If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."

II. PROCEDURE

To comply with Medicare regulations Waterbury Hospital will follow this standard procedure when attempting to collect a bill from a Medicare patient:

1. Medicare encounters that have a self pay after Medicare will be billed to the patient after Medicare has remitted payment.
2. Once the self-pay after Medicare balance will be referred to NCO (formerly OSI) approximately 23 days after payment. The patient will receive monthly patient statements, dunning messages and phone calls [on larger balances] according to predefined vendor processes. If the encounter remains unpaid after all attempts at collection have failed and 120 days past placement has occurred, the balance will be returned for referral to a Bad Debt collection agency. A minimum of 120 days must have elapsed since the first statement was sent to the patient.

    - According to the Waterbury Hospital's contractual agreement with the vendor the collection agency will follow the same collection processes for Medicare patients as they would for non-Medicare patients.

3. Medicare accounts which are deemed to be uncollectible (returned from the Bad Debt vendor after 1 year of inactivity) will be reflected on the hospital's annual cost report.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

NCO Referrals
Self Pay, Self Pay After Insurance, and Small Balance (x > $10 and x < $100)

CATEGORY: Credit & Collection	**Policy: NCO Referrals**
REVIEWED:06/10	**REVISED: 06/10**
RETIRED:	**Comments:**

Purpose: To provide support to the Patient Accounting Financial Services department for the dunning and collection of self-pay balances and selected third-party encounters.

I. POLICY

Waterbury Hospital has entered into a contractual arrangement with NCO for the purposes of self-pay and selected third-party collection services. NCO will be utilized to collect:

- Self-pay balances at day one
- Self-pay after insurance at day 23 after insurance payment
- And third-party insurance balances between $10 and $100.

Waterbury Hospital will schedule a bi-weekly meeting to review NCO reports, success rates, invoices, encounter reconciliations and address any other ad hoc issues that may arise.

II. PROCEDURE

NCO encounter referrals will adhere to the following process:

1. On a daily basis ProFit will identify encounters by the criteria below and mark them with pre-collection 'flag':
    a. Self Pay (No Insurance) - Referred one (1) day after discharge
    b. Self Pay after Insurance - Referred 23 days after balance has moved to the Self Pay benefit order
    c. Third-party insurance balances between $10 and $100 - Referred at 90 days after last generation date

2. These encounters are electronically transmitted daily to NCO.

3. Encounters are loaded into the NCO system.

4. If the encounter balance is the patient's responsibility NCO will start the patient statement process and dun patients according to predetermine vendor criteria. If the encounter balance belongs to a third-party payer NCO will bill the insurance carrier accordingly.

As the encounter progresses through the dunning and/or collection process NCO will manage all billing and patient correspondence.

- If insurance information is received during the dunning process, an on-site NCO Representative will update Cerner and generate a new claim. The encounter remains with NCO until it is resolved either by payment, or returned for collection or other resolution [write-off, small balance, charity care etc.].

Note: NCO will provide off-site resources to manage all payer and patient contact.

5. Should NCO determine that an encounter is uncollectible or deem the encounter to be a bad debt NCO will return the encounter to Cerner with a special cancellation code. These cancellation codes cause the encounter to be referred to a bad debt collection agencies dependent on specific criteria. [See Collection Agency Referral policy for details].
6. NCO also produces weekly reconciliation reports for all encounters that have been returned that are ***not*** considered bad debts. The Reporting Analyst will reconcile these encounters and return them to the work queues for billing, collection or follow-up activity.
    a. Based on the cancellation code the Reporting Analyst will route the encounter to the Patient Accounting or Customer Service Staff.

COMPENSATION

NCO has a contingency based contract with Waterbury Hospital. On a monthly basis, NCO will present an invoice reflecting all encounters paid in the prior month with associated fees. All contracts should be reviewed on an annual basis.

Waterbury Hospital
CREDIT & COLLECTION POLICIES

Discharged Not Final Billed [DNFB]

CATEGORY: Credit & Collection	Policy: Discharged Not Final Billed [DNFB]
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To define a policy and procedure for review and processing of DNFB claims in order to complete billing in a timely manner.

I. POLICY

It is the policy of Waterbury Hospital Health Center to meet or exceed the DNFB goal as established by the Director of Patient Accounting.

II. PROCEDURE

The DNFB goal has been established using the formula below and adding the result to obtain the total DNFB goal:

Inpatient:

Average Daily Inpatient Gross Revenue (90 day avg) X (Standard Delay Days (4) + 1 additional day)

Outpatient:

Average Daily Outpatient Gross Revenue (90 day avg) X (Standard Delay Days (6) + 1 additional day)

The DNFB report is ran daily by the Finance Department and reported via email to the Finance, Patient Accounting and HIM Departments. The Discharged Not Final Billed report can be found in ProFit Explorer Menu (Main Menu, ProFit Standard Report, and Claims Management).

The Director of PAFS, HIM, Finance, and other departments as necessary will meet weekly to review the DNFB report and identify issues resulting in the total DNFB exceeding the established goal.

The total DNFB should be reported monthly to senior leadership.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Reasonable Collection Effort

CATEGORY: Credit & Collection	Policy: Reasonable Collection Effort
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To define Waterbury Hospital's 'Reasonable Collection Efforts' in accordance with state and federal regulations.

I. POLICY

Waterbury Hospital will extend collection efforts which are reasonable and compliant with state and federal guidelines on the pursuit of patient due balances and referral to a collection agency.

[Note: Waterbury Hospital defines patient due balances as deductibles, coinsurance amounts and co-payments as adjudicated by third parties. Patients who have no insurance are considered to be responsible for full charges.]

II. PROCEDURE

Waterbury Hospital will extend reasonable collection efforts according to the following procedure:

1. At time of discharge [to include expirations] or conclusion of outpatient services, Encounters are placed in suspense for a specified number of days to allow charges to be posted and other functions such as coding, to occur. In-patient encounters, for example, are held for a minimum of 3 days, outpatients for 6 days.

2. Once the standard delay days have been exhausted and the coding process concludes, a final bill will be generated and sent to the third party payer for payment. If the patient does not have health insurance (registered Self-pay) the bill will be sent directly to the patient for payment.
   - After the initial bill has generated self-pay encounters are referred to an outsourced vendor (NCO) which acts as an extension of the business office and handles all Self-pay balances.
     - Registered self pay is sent to NCO at day 1
     - Self pay after insurance is sent to NCO 23 days after insurance (primary, secondary or tertiary) has paid the claim.

3. In accordance with hospital policy, self-pay patients receive a series of three (3) statements at approximately 30-day intervals, from the outsourced self-pay vendor NCO. The statements include dunning messages which are progressive in informing the patients

of their obligation, and include notices that the account may be referred to a collection agency if the balance remains outstanding.

Note: At any point along the self-pay collection cycle a patient can inquire and/or request to be considered for a variety of discounting, charity or grant programs. Signage is posted in all Registration and Customer Service areas and is provided to self pay patients at the time of service. In addition, all patient statements include information instructing them on the methods of accessing financial counseling assistance.

4. After the final statement has been sent to the patient, any outstanding balances that pertain to a self pay or self pay after insurance are returned to Waterbury Hospital electronically. On a daily basis, encounters are returned and referred to a collection agency and automatically written off as bad debt unless it has been determined that the patient is Indigent or Medically Indigent as per hospital policies.

   Note: Indigent or Medically Indigent Inpatients – A determination as to whether a self-pay in-patient is indigent or Medically Indigent will be established by R&B Medicaid Services acting as a Medicaid/SAGA entitlement agency acting on behalf of Waterbury Hospital.

5. For all other patients, Waterbury Hospital will apply customary methods for determining qualification of patients for the various discounting and free bed programs (if available).

   Note: The patient's indigence will be determined by Waterbury Hospital and its representatives, not by the patient. In determining the patient's indigence Waterbury Hospital will take into account an analysis of the patient's total resources, which include, but are not limited to, assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, income and expenses.

6. Waterbury Hospital must also determine that no source other than the patient would be legally responsible for the patient's medical bill (i.e. Title XIX, Welfare, etc.)

7. The patient's file should contain documentation of the methodology used to determine indigence in addition to all backup information to substantiate the determination.

8. For balances that are not fully qualified for discounting, and/or outstanding deductibles and co-payments, Waterbury Hospital will extend reasonable collection efforts to resolve the balance due. If there has been no payment activity or additional communication with the patient, the hospital will determine that the outstanding amounts are uncollectible (pertaining to deductible and coinsurance) and record the outstanding balances as bad debt on the hospital's books.

   Note: Medicare Bad Debts under State Welfare Programs - Effective with the 1967 Amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically or medically needy persons. Any portion of such deductible or coinsurance

amounts that the State is not Obligated to pay can be included as bad debt under Medicare, provided that the requirements for determining indigent or medically indigent have been applied and met or if the patient meets other collection efforts as noted above.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Public Act 02-92 Itemized Bills

CATEGORY: Credit & Collection	Policy: Itemized Bills
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To inform self pay patients that they can request an itemization of all charges.

I. POLICY

It is the policy of Waterbury Hospital Health Center to comply with Public Act 02-92, which requires that all self pay patients may receive a copy of all hospital charges relating to their inpatient stay.

II. PROCEDURE

A self pay notice will be handed out to self pay inpatients visited by R&B Medicaid.

The message on self pay demand and summary bills will be modified to refer to Public Act 02-92 and inform self pay inpatients that they may, upon request, receive a full itemization of all charges. "Such admission forms shall also include a conspicuous notice specifying the name and contact information of a person whom the patient may contact to request a copy of the hospital charges related to the patient."

Waterbury Hospital Health Center shall include in their bills to patients, and to third party payers, unless previously furnished, an explanation of any items identified by any code or by initials.

Waterbury Hospital Health Center shall provide the patient with an itemized bill not later than thirty [30] days after the date of such request. Such itemized bill shall identify, in plain language pursuant to chapter 742, each individual service, supply or medication provided to the patient by the hospital and the specific charge for such service, supply or medication.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Small Balance Write-off

CATEGORY: Credit & Collection	Policy: Small Balance Write Off
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To establish a reasonable and customary balance threshold for small balance write-off adjustments.

I. POLICY

Following the extension of reasonable and compliant collection efforts Waterbury Hospital will adjust small balance debit and credit accounts.

The balance threshold for small balances write-off are as follows:

- Small Debit Balances – $9.99 and Below
- All Credit Balances are monitored and reported via the Credit Balance Report.

II. PROCEDURE

1. Each evening at 5PM EST, the Cerner System will identify and adjust debit balances which qualify for the small balance write-off adjustment policy.

2. On a monthly basis the Reporting Analyst will review the ATB to confirm that the automated Small Balance Adjustment Process is operating as directed.

    a. If the Reporting Analyst finds that small balance accounts are not being adjusted appropriately after reviewing the ATB the Reporting Analyst will create a spreadsheet for the Assistant Director of Patient Accounts to review. The Assistant Director will then route the spreadsheet to the Cash Posting Supervisor who will direct the Cash Application Staff to post the small balance adjustments in Cerner.
    b. The Reporting Analyst will also file a help desk call to alert Waterbury Hospital IS that the automated process is not working correctly.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

NGS Additional Documentation Requests (ADR) Policy

CATEGORY: Credit & Collection	**Policy: NGS ADR Policy**
REVIEWED:06/10	**REVISED: 06/10**
RETIRED:	**Comments:**

Purpose: Additional Documentation Requests (ADR) are requests for medical documentation for claim adjudication by NGS Medicare. NGS requires that hospitals take specific steps when responding to ADRs. NGS Medicare has set a specific timeline of 30 days for responding to Progressive Corrective Action Requirements and the processing of ADRs.

I. POLICY

It is the policy of Waterbury Hospital Support Services to efficiently disseminate ADRs [National Government Services (NGS) Medicare Additional Development Requests] to hospital departments to ensure timely follow-up back to NGS Medicare.

Failure to provide Medicare with the requested documentation within established guidelines will result in lost reimbursement.

The following processes and reports are available for the analysis and reporting of Accounts Receivable:

1. On a daily basis, billing support staff will query the Fiscal Intermediary Standard System (FISS) system for new ADRs. Some may be sent via mail. The forms are printed.
2. The ADR forms will be disseminated to the various departments for pulling of records.
3. The billing support staff will document in Cerner that the ADRs have been sent to the appropriate departments.
   - Behavioral Health will be responsible to document in Cerner that the documentation has been sent to NGS.
   - All other areas will be monitored by support services
4. The ADR with the medical documentation attached will be returned to NGS Medicare via the United States Postal Service (faxed copies will not be accepted) within the 30-day timeframe.
5. The billing support staff will enter the FISS to review the claim status and will document the receipt of the ADR in Cerner.
   - Claim status location SM5CLK means the records have been received
6. Encounters that pass beyond the 30 days in suspense are rejected by the NGS Medicare system and will be appealed according to Medicare's Appeal Policy and Process.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Credit Balance Policy

CATEGORY: Credit & Collection	Policy: Credit Balance Policy
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To define the process by which Waterbury Hospital reviews and certifies Credit Balance accounts, issues account refunds and adheres to hospital QA policies for select staff.

I. POLICY

Waterbury Hospital aims to keep total Credit Balances less than or equal to 2% of the total Net A/R. It is the responsibility of PAFS staff members to adhere to this policy by identifying, reviewing and processing credit balance refunds in a timely manner to patients and third-parties. Waterbury Hospital will generate a credit balance report on a monthly basis to for PAFS staff (Billers and Collectors) to review and analyze. Each encounter is reviewed by PAFS staff to determine if the patient or the third party payer is entitled to a refund.

II. PROCDEDURE

The Credit balance report is produced monthly. The data is sorted by financial class, in an ascending dollar format (i.e., large credit balances appear at the top of the work list).

PAFS Staff (Billers and Collectors) are expected show a reasonable attempt to work their Credit Work List and keep the volume of accounts current.

PAFS Staff manage the Credit Balance work list and "work" encounters using the following process:

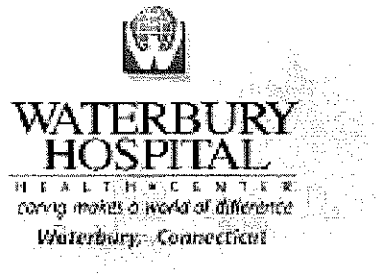
1. Each Credit Balance encounter shall be reviewed and analyzed to determine the cause of the negative balance:
    a. PAFS Staff are required review the patient account in Cerner, review the EOB (or 835 File), consult the payer contract and/or fee schedule (if available), and confirm the posted payment matches the patient record in Cerner
2. If the Credit Balance is not accurate due to a posting error, the PAFS Staff member shall request that the appropriate adjustment be applied
3. If the Credit Balance is accurate the PAFS Staff member shall take the following action:
    a. Patient refund - if the patient has no other open patient balance due encounters the patient account should be refunded
    b. Insurance overpayment/error - insurance companies only be refunded if determined overpayment is due (some payers will be issued a credit, others will recoup through the remittance process).
4. PAFS shall request a refund via the refund process and only by using the appropriate approved Patient Refund or Third Party refund forms.

5. Once Finance completes the refund check it will be returned to PAFS staff for mailing and attachment to remittance documents.

Attachments:

Patient Refund Form
Insurance Refund Form

Patient Refund Form



Refund To:
John Doe
123 Main Street
Waterbury, CT 06708

Patient Name: Doe, John
Account #: 123456/ FIN= 12345678

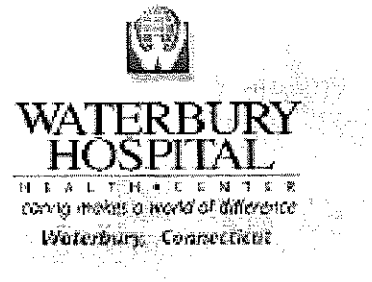
Sup/Dir Signature:_____

Amt: _____

Batch#: _____

DOS: _____

Insurance Refund Form



Refund To:

_____

_____

_____

_____

I.D. #:_____

DOS: _____

Patient Name: Doe, John
Account #: 123456/ FIN# 12345678

Sup/Dir Signature:_____

Amt: _____

Batch#: _____

WATERBURY HOSPITAL HEALTH CENTER
CREDIT & COLLECTION MANUAL

Administrative and Provider Liable Adjustments Approval

CATEGORY: Credit & Collection	Policy: Administrative & Provider Liable Adjustments Approval
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

DEFINITIONS:

Contractual Adjustment: the difference between revenue at established rates and the amounts realized from third-party payers under contractual agreements

Administrative Adjustment (AA): a type of adjustment that may be applied to a patient account to account for revenue that is deemed partially or fully uncollectible and must be written off (i.e. bad debts, charity care, etc). ***Requires approval***

Provider Liable Adjustment (PLC): a type of Administrative Adjustment that may be applied to a patient account to account for lost revenue that is a direct result of errors made by Waterbury Hospital Physicians, Clinical Staff, Coding Staff, Administration, Patient Accounting and others (i.e., timely filing, coding errors, diagnosis mismatch, billing for uncovered services, failure to file an appeal within the specified limits, etc.) ***Requires approval***

PURPOSE:

To outline the procedure for submitting and approving Administrative and Provider Liable Adjustments.

POLICY:

Waterbury Hospital Patient Accounting Staff will request adjustments to a patient's bill according to process outlined below. These Administrative Adjustments will only be approved and processed in accordance with this policy.

All Administrative and Provider Liable adjustments will only be applied once all collection efforts have been exhausted including appeals. All staff must research denial information and provide documentation to support the adjustment.

> **Example:** Payment is denied due to authorization of inpatient days. The account will only be eligible for adjustment once the proper hospital staff has reviewed the claim and appealed for partial or full payment and the payer has made a final determination.

All Administrative and Provider Liable adjustments greater than $10.00 will require approval from the Patient Accounting management team. Adjustments less than $10.00 will not require approval. The following approval levels will apply:

Adjustments are subject to approvals as follows:

Under $10 does not require approval

$10-$9,999 requires approval from the Assistant Director of Patient Accounting

$10,000-$24,999 requires approval from the Director of Patient Accounting

Over $25,000 requires approval from the Chief Financial Officer

Staff will submit adjustments for approval per the procedure detailed below, and then document the request along with a detailed note explaining the reason for the request in the notes section of the applicable account in Cerner. (Notes should always be made in the Cerner system to justify/explain the reason for the write-off.)

After obtaining approval, the Posting staff will process the adjustment.

PROCEDURE:

Patient Accounting Staff will:

1. Review assigned accounts according to established collection and follow-up guidelines.
2. Identify those accounts that meet Administrative and PLC Adjustment criteria.
   - Administrative Adjustment Criteria:
     - Account has been through the payment cycle and the remaining balance is uncollectible and requires no further PAFS follow up activity.
   - PLC Adjustment Criteria:
     - Same as Administrative Adjustment criteria with the exception that the reason for the uncollectible balance is due to Hospital error.

   Ensure all appeals have been completed and the Hospital has received maximum reimbursement before considering adjustment.
3. Collect all data and supporting documentation relative to the request for administrative write-off. Ensure all collection efforts are and the reason for the adjustment is noted in Cerner.
4. Prepare daily Adjustment Request Log (See attached) and a detailed explanation.

5. The approver will review adjustment request and sign approval. Forward all Adjustment Request Logs to the Assistant Director of Patient Accounting. The Assistant Director of Patient Accounting will review and forward the request on to the CFO and Director of Patient Accounting.
6. Once approved, the Posting Staff will process the Administrative Adjustment in the system using appropriate adjustment code and file supporting documentation.

ATTACHMENTS:

Waterbury Hospital Adjustment Log

Waterbury Hospital Adjustment Request Log

Date	Encounter Number	Patient Name	Adjustment Amount	Credit/ Debit	Payer	Reason for Adjustment	Adjustment Code

Draft for discussion purposes only.

Revision Date: 2/4/08

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Refund Process Policy

CATEGORY: Credit & Collection	Policy: Refund Process Policy
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To resolve credit balances in a timely manner either through a refund to the patient, third party carrier or removing an inappropriate adjustment on the account. Any refunds that are not returnable will be filed as unclaimed property with the State of Connecticut in accordance with Sec. 3-65a of the Connecticut General Statute (CGS).

I. POLICY

PAFS staff members are required to manage Credit Balance patient accounts in accordance with Waterbury Hospital's Credit Balance Policy. In the event that credit resulted from an overpayment from either a third party or patient payment, the resulting overpayment must be returned to the appropriate party.

II. PROCEDURE

Encounters with potential overpayments & credit balances must be addressed promptly. Credit balances and/or overpayment discrepancies can result from:

- Payments made by an insurance carrier and/or another responsible party for an amount greater than expected
- Duplicate payments/contractual entries
- Misapplied charges/credits
- Or incorrect patient account adjustments posted as financial transactions to the patient's encounter

Overpayments must be returned to the appropriate party via the following process:

Self-Pay Credit Balance

1. Review the patient account
    a. If the patient account has no other open patient balance due encounters proceed with refund
    b. If there are open patient balance due encounters for the same patient account, transfer the post the credit balance to the corresponding patient encounter
        i. Be certain to provide detailed comments on both accounts noting the reason for the balance transfer
2. If no open balances exist proceed with the refund
3. The PAFS staff member shall request a refund via the refund process (below) and only by using the appropriate Finance approved refund forms

Insurance Credit Balances

1. Review the posted remittance
2. Validate the allowance and payment to ensure accuracy of calculation and posting action
3. If the remittance and posting actions are accurate the collector should notify the payer in accordance with the Credit Balance Policy
4. If a refund check is required the PAFS staff member shall request a refund via the refund process (below) and only by using the appropriate Finance approved refund forms

Request Refund Process

1. Refund requests are required to be made using the 'Letter' functionality in ProFit (this form must be used in place of an itemized bill)
    a. Complete the form and staple the relevant pieces of remittance

2. Prepare an allowance sheet to reverse the amount of refund being sent

    Note: the allowance sheet is reviewed by the Assistant Director of PAFS.

3. Record the refund in the debit column of allowance sheet applying the appropriate refund alias code

    a. Batch the refunds and put them in the refund bin for the Assistant Director of PAFS to review and authorize
    b. The batch should include the refund form with any attachments, the allowance sheet and a receipt tape (*the PAFS staff member should double check all totals*)
    c. When the batch is returned, assign a batch number (*the refund batch book is kept by the Assistant Director of PAFS*)
    d. Log the batch number, the number of encounters, the dollar amount, and record your initials in the log book
    e. Once all above steps have been completed, send the batch to Finance
    f. Finance will process the refund within one week of receipt (*depending on cash budget available for refunds*)

Special Handling Requirements

- State and City Welfare funds are processed on a payment appeal form. This form is sent to the state and the monies are recouped on future remits
- Medicare Part A refunds are resolved via adjusted or voided claims. Credit balances due to Medicare are reported on a quarterly basis utilizing specific filing instructions as per Medicare regulations. Any credit outstanding at the time of quarterly credit report filing will be logged on that report
- Medicare B is to be refunded via check and follows the insurance guidelines
- Blue Cross is handled in a similar fashion with some exceptions [out of state, nationals, Blue Shield] which require refund check

Returned Refund Checks

Returned refund checks will be given to the Assistant Director of PAFS. The Assistant Director of PAFS will review the returned check and determine if the check should be reissued, turned over to the state as an unclaimed property.

Note: If the refund has to be voided for any reason, use the "reissuing refund" alias code to document the credit.

Returned refund checks are investigated by the Assistant Director of PAFS to determine appropriate action needed to resolve the fund. If the refund check is returned for an invalid address, a search is done to obtain the correct address. If an address is not available the check is turned over to the State of Connecticut as unclaimed property.

If the check is returned due to no forwarding address or patient deceased, the check is turned over to the State of Connecticut as unclaimed property.

Note: Any refunds that are not returnable will be filed as unclaimed property with the State of Connecticut in accordance with Sec. 3-65a of the Connecticut General Statute (CGS)

To turn the check over to the State of Connecticut the following steps are taken:

- A comment is written on the refund check explaining the reason why the check needs to be turned over to the state and documented on the encounter in Cerner
- The Assistant Patient Accounting Director writes up two allowances. One allowance reverses the refund to create a credit on the Encounter. The second allowance debits the Encounter using the appropriate alias code for unclaimed property
- The refund check is then sent to the Finance department to forward on to the state.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

MEDICARE - REFUND PROCESS

CATEGORY: Credit & Collection	Policy: Medicare Refund Process
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To define the process by which Waterbury Hospital issues a Medicare refund and to certify Waterbury Hospital's adherence Medicare's Quarterly Credit Balance Report policy.

I. POLICY

Waterbury Hospital will generate Medicare credit balance report on a monthly basis for any encounter with a Medicare health plan listed. Each encounter is reviewed by WH staff to determine if Medicare is entitled to a refund.

II. PROCDEDURE

After each credit balance encounter is reviewed by WH staff to determine if Medicare is entitled to a refund. WH staff will follow this process:

1. If Medicare is due a refund, PAFS Staff will adjust the UB04 in the NGS FISS System so the claim qualifies for a payment retraction.

2. Once processed by Medicare, the retraction will appear on a remittance advice and the allowance will be reversed at the time of posting.

QUARTERLY REPORT

Medicare regulations require a quarterly credit report. (Hard copy and disk). This report tracks and identifies any encounters not captured by the above process. The report is divided by inpatient and outpatient encounter status.

Once an encounter is listed on this report, it cannot be repeated. Follow-up will have to be done with Medicare on an individual encounter basis.

The staff member responsible for completing the quarterly report and the Vice President of Finance (Chief Financial Officer) are responsible for signing an attestation form. This form (attached) is sent to Medicare along with the quarterly report.

ATTACHMENTS:

Medicare Credit Balance Report Certification

FORM CMS-838
Medicare Credit Balance Report
Certification Page

MEDICARE CREDIT BALANCE REPORT CERTIFICATION

The Medicare Credit Balance Report is required under the authority of Sections 1815(a), 1833(e), 1880(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER (S)

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by

_____ _____
Provider Name Provider 6-Digit Number

for the calendar quarter ended _____ and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations and instructions.

(Sign) _____
Officer or Administrator of Provider

(Print) _____
Name and Title

(Print) _____
Date

CHECK ONE:
[ ] Qualify as a Low Utilization Provider.
[ ] The Credit Balance Report Detail Page(s) is attached.
[ ] There are no Medicare credit balances to report for this quarter. (No Detail Page(s) attached.)

Contact Person Telephone Number

FORM APPROVED
OMB NO. 0938-0600 (10/2002)

MEDICARE CREDIT BALANCE REPORT
(FORM HCFA-838)

Waterbury Hospital
CREDIT & COLLECTION MANUAL
Past Due Patient Account Escalation Policy

CATEGORY: Credit & Collection	Policy: Past Due Patient Account Escalation Policy
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To define "problem" accounts and provide guidance on how to manage patient accounts that require special handling.

I. POLICY

Unresolved patient accounts with balances greater than $10,000 aged 60 days or greater from the final billed date (90 days or greater for Medicaid and SAGA) must be escalated to the Assistant Director of Patient Accounting.

It is the obligation of the PAFS Collectors to press third party payers for reimbursement on all Past Due claims. At a minimum the collector should make three (3) distinct collection (reimbursement) attempts with the third party payer before escalating an encounter.

Note: If the hospital is to receive prompt payment from third parties, it is important that the initial billing statement to the third party be prompt, accurate, and clear. Reimbursements can be justifiably delayed if the required forms, medical information, and/or signatures are not provided to the third party payer.

II. PROCEDURE

A necessary success factor to resolving patient accounts is recognizing the "problem account" as soon as possible and quickly initiating corrective action. For encounters with total outstanding balances greater than $10,000 the following steps should be taken and/or observed prior to escalating the encounter to the Assistant Director of Patient Accounting.

1. Per the Situation Response Guidelines (SRG) the PAFS Collector shall begin making collection calls 15 days from the Final Bill Date.
    - The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.
    - Based on the outcome of the initial follow-up phone call the PAFS Collector shall set a specific follow-up date using the Action Code Functionality in the patient accounting work driver.
2. If the encounter is still unresolved after two (2) phone calls to the payer the PAFS Collector shall request to speak with a Claim Adjudication Supervisor.
    - The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.

- Based on the outcome of the second follow-up phone call the PAFS Collector shall set a specific follow-up date using the Action Code Functionality in the patient accounting work driver.

3. If the encounter remains unresolved after three (3) phone calls to the payer and escalation to the Claim Adjudication Supervisor the PAFS Collector shall notify the Assistant Director of Patient Accounting via email that the patient claim is severely past due.
    - The collector shall document this internal escalation request in the Patient Record in the Patient Accounting System.
4. Immediately after notifying the Assistant Director of Patient Accounting that the encounter is past due the PAFS Collector shall notify the patient or the patient's estate, when possible, of their contracted designee's failure to adjudicate their claim.
    - The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.
5. At this time the Assistant Director of Patient Accounting will document the encounter in the escalation log (attached) and will inform the PAFS Collector that the encounter needs to be escalated to the Payer Contract Representative or Account Manager via the payer preferred method of inquiry (e.g., email, phone call, BCBC Past Due Workbook, etc.).
    - The collector shall document this escalation inquiry and record notes in the Patient Record in the Patient Accounting System.
6. If the encounter remains unresolved after two (2) escalation attempts with the Payer Contract Representative or Account Manager the PAFS Collector shall follow-up with the Assistant Director of Patient Accounting.
7. The Assistant Director of Patient Accounting will now be responsible for escalating the encounter to the Payer Contract Representative or Account Manager.
    - The Assistant Director of Patient Accounting shall document this escalation inquiry and record notes in the Patient Record in the Patient Accounting System.
8. If the encounter remains unresolved after two additional (2) escalation attempts with the Payer Contract Representative or Account Manager the Assistant Director of Patient Accounting shall escalate the encounter to the Director of Patient Accounting.
9. Following escalation the Director of Patient Accounting shall escalate the encounter the Director of Payer Contracting and CC: the Waterbury Hospital CFO.
10. The Director of Patient Accounting should bring the details of the patient encounter the next available Operations Committee Meeting.

ATTACHMENTS:

Past Due Patient Account Escalation Log (Sample)

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Medicare Payment Variance Policy

CATEGORY: Credit & Collection	Policy: Medicare Payment Variance Policy
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To provide guidance on how to manage suspected Medicare underpayments and encounters with potential outlier payment opportunities.

I. POLICY

It is the policy of Waterbury Hospital to review Medicare encounters with initial charge balances greater than $100,000 using the Trendstar and IMaCS Systems. If it is determined that Medicare underpaid the claim according to the both systems, the High Dollar Medicare Collector will be responsible for pursuing additional payment via the billing and/or follow-up process.

II. PROCEDURE

The Decision Support Coordinator (Finance) will identify encounters for the Customer Service Supervisor using the "Charges Over $100,000 Medicare Part A Pmt" Report out of Trendstar. The Customer Service Supervisor will run a variance report out of IMaCS and compare both reports for outliers. If necessary, the Medicare CWF will also be utilized to assure accuracy. The process for identifying Medicare encounters is as follows:

1. The Customer Service Supervisor will track Medicare encounters with initial charge balances greater than $100,000 via the IMaCS variance report.

    - The Customer Service Supervisor will flag reviewed accounts to avoid duplication of work and determine no additional follow up is necessary.
    - If cases require follow up, the encounters will be forwarded on to the Assistant Director of PAFS to assure appropriate action is taken.

2. As encounters with initial charge balances greater than $100,000 are adjudicated and paid by Medicare, the encounters will flow to a report in Trendstar to be generated, bi-monthly, by the Decision Support Coordinator. The report will run the 15th and last day of each month and be sent via email to the Customer Service Supervisor for review.

3. The Customer Service Supervisor will be responsible for logging into the IMaCS System and confirming the DRG / Outlier payments for the specified encounter.

- ***Payment Variance Requires Follow-up:*** If the payment variance is greater than $100 the Customer Service Supervisor will notify the Assistant Director of PAFS that the encounter was not paid correctly and an additional payment opportunity potentially exists.

4. Once notified, the Assistant Director of PAFS will review the encounters with WH Finance to verify the underpayments.

5. Based on the input from Finance, the necessary action will be taken on the encounter, either through the NGS FISS system or during reporting.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Worker's Compensation / MVA Process

CATEGORY: Credit & Collection	Policy: Worker's Compensation / MVA Process
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To define the process by which Worker's Compensation and Motor Vehicle Accident (MVA) claims are entered into and tracked in the Patient Accounting System.

I. POLICY

Waterbury will enter and track all WC/MVA claims in the Patient Accounting System. Review of encounters will need to occur within 5 days of the date of service, by Patient Access. Holds will be reviewed and removed only after sufficient evaluation. Encounters need to be updated and reviewed in a timely fashion to ensure bills are not held up within the system.

II. PROCESS

All Workers Comp and MVA encounters will need to be reviewed by Patient Access for accurate demographic and insurance information within 5 days of service. To this end, a new hold has been created in Cerner called **COMP MVA HOLD**. The Comp MVA Hold will prevent any billing from taking place until the encounter is reviewed.

The hold will be applied automatically by the system to all outpatient and emergency room encounters [to include EDSURG] when an encounter is registered with the following primary health plans:

- Workers Comp City of Waterbury
- Workers Comp State of CT-Gab Robbins
- Miscellaneous Worker's Comp Plan
- MVA

If one of the above health plans was added as secondary in error and then swapped to primary, the hold will be automatically placed.

Once reviewed and correct information has been obtained, the encounter will be documented and the hold removed [in Profit]. The encounter will then bill. **The hold will always need to be manually removed by Patient Access.**

There are some caveats, however, that are important to note:

- If one of the above health plans was added as primary and then removed, the hold will need to be manually removed.
- Outpatients and ED patients who are registered as outpatients first and then changed to inpatient will need to have the hold manually removed.
- ODS service is not included.

The hold will also appear on the Billing Entity Hold Report which will be produced weekly and distributed to Central Registration. Any encounters reflected on the Hold report will be reviewed by Central Registration/ED Registration and completed. Once completed, the hold will be manually removed by Patient Access. The Hold report will be closely monitored for timeliness by Patient Access.

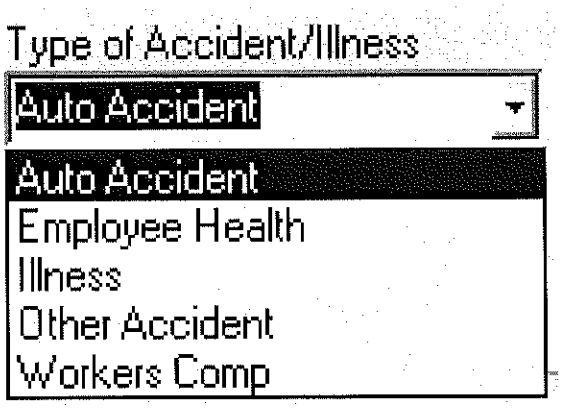
DATA QUALITY

Workers Compensation:

- The Worker Compensation carrier [not the employer] is required.
- That information can be obtained via the document prepared by the Agency collector or a phone call to the employer.
- In the Illness/Accident field select Type of Accident/Illness **Workers Comp** and enter appropriate date and time of accident in order to assign the correct UB04 occurrence code.
- If the workers comp carrier cannot be obtained then workers comp should not be entered and encounter should be registered with the patient's medical health plan, **with exception of Medicare**
- If there is no medical health plan then register self pay

MVA

- Enter the medical health plan if available
- In the Illness/Accident field select Type of Accident/Illness **Auto Accident** and enter appropriate date, time and location [State] of accident to assign the correct UB04 occurrence code.
- If the MVA information cannot be obtained - **with the exception of Medicare** - then MVA health plan should not be entered and encounter should be registered with the patient's medical health plan (exception Medicare)
- If no medical health plan, register as self pay



Patient Access Responsibilities/Expectations

- The Patient Access team will make four attempts to obtain Worker's Comp/MVA for all necessary encounters.
- The four attempts will consist of the following:
    1. Telephone call to the employer
    2. Telephone call to the employer
    3. Telephone call to the patient.
       Note: If patient is reached but is unable to provide information at the time, the patient will be informed that he/she has 3 business days to provide Waterbury with the information or they will assume responsibility for making their payment in full.
    4. Send Worker's Comp/MVA Notification letter to the patient.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

High Dollar Self Pay Monitoring

CATEGORY: Credit & Collection	Policy: High Dollar Self Pay Monitoring
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

POLICY: It is the policy of Waterbury Hospital to closely monitor high dollar self pay encounters that are referred to the self pay outsourcing vendor in order to ensure appropriate due diligence and referral to collection.

PROCEDURE:

1. On a monthly basis, a file will be produced for all outstanding self pay balances greater than $10k that have been outsourced.

- The file is forwarded to our outsourcing vendor for review
- Vendor will review each encounter for appropriate activity and report back a status.
- Vendor will ensure that the encounters are in the appropriate workflow.

2. Waterbury Hospital will review the outsourcing status for appropriate activity.

3. At mid-month, collection referral totals will be reviewed with the outsourcing agency.
   - Forcasting for referrals for remainder of month will be done.
   - Determination of high dollar cases to be referred will be done
     - May be done on a case by case basis

4. At end of month bad debt referrals will be again reviewed to insure that there are no anomalies due to high dollar, system or other issues.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Late Charges

CATEGORY: Credit & Collection	Policy: Late Charges
REVIEWED:06/10	REVISED: 06/10
RETIRED:	Comments:

Purpose: To ensure that billed claims to third party payers are accurate, account for late charges, and are processed by Patient Accounting Financial Services in a timely manner.

I. POLICY

All charges must be submitted within 72 hours of discharge. A charge is considered late after 72 hours.

Waterbury Hospital will be compliant with Medicare Regulations with regard to submitting and processing of late charges. All late charges must be worked daily by the billing staff (excluding weekends).

All late charges received prior to claim submission date will be added to the claim. Late charges under $250, received after the claim submission date, will be written off to the Late Charge Allowance transaction alias 2193 (debit) or 2103 (credit). Late charges over $250, received after the claim submission date, will be reviewed by Patient Accounting Financial Services.

II. PROCEDURE

Processing of Late Charges Received after Claim Submission

1) Late charges of $250 and under will be submitted as an allowance for the transaction alias:
   a) **2193 (debit) Late Charge Allowance**
   b) **2103 (credit) Late Charge Allowance**
2) Late charges greater than $250 will fall into the follow up staff's queue
3) Follow up staff will review the charges and submit the bill according to the Medicare Processing Manual (50.3 - Late Charges (Rev.1, 10-01-03) HO-411.3, HO-IM411.3)
   a) Charges omitted from the original bill must be submitted to the payer on an adjustment bill (bill type xx7)
      i) Adjustment bills will contain all late charges and the original charges billed earlier
      ii) Adjustment bills should be submitted for
         (1) Services on the same day as an outpatient surgery (subject to the ACS limit)
         (2) All inpatient accommodation charges
         (3) All inpatient PPS ancillaries
4) Follow up staff process late charges on a case-by-case basis and analyze adjustments as such
5) Follow up staff's actions are documented in Cerner

Monitoring Late Charges

1) It is the responsibility of the Finance Department to monitor the late charges
2) Finance Department is to follow-up with specific departments showing excessive late charges.

Waterbury Hospital

CREDIT & COLLECTION MANUAL

PRESUMPTIVE ELIGIBILITY FOR UNINSURED NEWBORNS & PREGNANT WOMEN

CATEGORY: Credit & Collection	**Policy: Presumptive Eligibility for Uninsured Newborns & Pregnant Women**
REVIEWED:06/10	**REVISED: 06/10**
RETIRED:	**Comments: PE for Pregnant Women implemented 3-1-2010**

PURPOSE: To comply with state of CT statutes (Section 17b-277, 292) concerning expedited Husky eligibility for uninsured newborns & pregnant women as contracted.

POLICY:
It is the policy of Waterbury Hospital to comply with the statutes governing presumptive eligibility of the Husky program for uninsured newborns & pregnant women..

PROCEDURE:
This is a collaborative process between several departments of Waterbury Hospital [FBC, Patient Access, Patient Accounts), Staywell and The Department of Social Services [DSS].

GENERAL INFORMATION:

Staywell
When a Staywell mom reaches the eighth month of pregnancy, their W-1HUS application will be couriered to Waterbury Hospital to the attention of our R&B Medicaid Liaison. These applications will be kept on file.

Registration
Self Pay patients presenting for registration to FBC will be queried by the registrar, to determine if they are a Staywell patient. This information is documented in the encounter.

Patient Access
On a daily basis, the insurance verifier will visit FBC and pick up all W-416 forms [Notification of Newborn].
The Insurance Verifier reviews all self pay moms for active Medicaid and works closely with R&B liaison on any without coverage.

PROCEDURE
Monday thru Friday [includes Sunday admissions]

1. FBC notifies Bed Control when mom has given birth. Bed Control will double-check if Mom is with Staywell.
2. The R&B Medicaid liaison monitors a daily self pay inpatient queue and obtains the patient demographic facesheet from Patient Access.
3. For Staywell moms, liaison will check for W1-HUS application on file.
    a. If on file, liaison will bring to floor visit to add baby to form
    b. If not on file, liaison will fill out application for mom and baby
    c. The liaison also completes the newborn certification of Identity, W-1009.
    d. R&B Liaison gives Mom the governor's letter and explains the new process.
4. R&B Liaison obtains the W-416 form from Insurance Verifier and faxes all 3 forms to ACS.
    a. Customer Service representative places a Healthy Start Hold on the encounter for follow up.

Friday evening and Saturday
Before leaving work on Friday, the R&B liaison will bring the Staywell applications to Family Birthing [FBC].

- Births are called down to Bed Control. Bed Control will call the FBC CIA if a self pay baby has been born.
- The CIA will check the file for a Staywell application.
    - If on file, the CIA will have patient sign applications and complete any necessary information.
    - If not on file, the CIA will give the patient the applications, review them and have the patient sign the applications.
- In both instances, the signed applications will be placed back in the file.

- On Monday, the R&B liaison will check for self pay babies born over the weekend, validate all applications and fax to ACS.

Holidays
During holidays that extend the weekend, both the R&B liaison and FBC will work out a schedule for coverage.

Discharge
1. Most FBC patients stop in Customer Service on discharge. Information for Medicaid eligibility process is confirmed for moms who are uninsured.

Post-Discharge Staywell Follow-up
Customer Service

1. A letter is sent to the patient asking them to contact Customer Service for follow through with the Medicaid process.
2. Customer Service representative monitors all Healthy Start Holds. After approximately 2 weeks, if there is no contact with the patient, the Customer Service Representative faxes a list of outstanding cases to Staywell [Derricia Parker]
3. Staywell faxes list back with ID# or status if still pending.
4. Customer Service representative continues to follow up with Staywell on any pending cases.

Post-Discharge Presumptive Eligibility Follow-up

Following the Newborn Coverage flow chart provided by DSS, ACS will determine if the case is Husky A or Husky B and will route it to the proper channel.

If necessary, ACS and hospital will communicate regarding questions and / or missing information.

Coverage is granted and hospital is notified.

*****For PE for pregnant women, follow the guidelines as defined by the State of Ct for Medicaid Certified Entities, which is very similar to the process above.**

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Accounts Receivable Analysis

CATEGORY: Credit & Collection Policies	POLICY: Accounts Receivable Analysis
REVIEWED: 06/10	REVISED: 01/07, 12/07,06/10
RETIRED:	Comments:

PURPOSE: To provide an outline of reports and software applications which are utilized for the analysis of Accounts Receivable.

POLICY:

It is the policy of Waterbury Hospital to regularly review the Accounts Receivable via various methods/processes, in order to insure the constant maintenance of billed AR for fiscal viability.

The following processes are available for the analysis and reporting of Accounts Receivable:

PATIENT ACCOUNTING REPORTS/QUEUES

Utilizing the Cerner system Workflow Manager application, various queues are assigned to staff according to their specific financial class responsibilities or tasks.

General Rules:

- High Dollars are worked first
- Third-party follow-up is performed within timed intervals for maximum productivity.
- Escalation to management is required for difficult cases which cannot be resolved, after all efforts have been expended.

Various eports can also be utilized and a listing of these reports can be found in Explorermenu.exe.

Note: Patient Accounts staff is currently performing follow-up in the PWC Bulldog application until Cerner upgrade to 2010.02.
With the upgrade, queues will be rebuilt and processes will be revised. Follow-up will be transferred back to Cerner.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

R&B MEDICAID SOLUTIONS

CATEGORY: Credit & Collection	POLICY: R&B Medicaid Solutions
REVIEWED: 06/10	REVISED: 03/06, 01/08,06/10
RETIRED:	Comment:

PURPOSE: To identify self pay patients who will qualify for Medicaid/SAGA entitlement.

Policy: R&B Medicaid Solutions is a contracted agency of Waterbury Hospital, responsible for the identification of self pay patients who will qualify for Medicaid/SAGA entitlement, and to aggressively pursue resolution of that entitlement.

Procedure:

- On a daily basis, the R&B liaison will identify self pay inpatients and outpatients from various sources: IP Self Pay Work queue, Central Registration referrals of high-dollar outpatient services.
- Liaison will compile a list of patients to be interviewed and visit patients while in-house.
- Using their laptop, liaison will be able to determine if patients meet the categories for possible entitlement to Medicaid/Saga.
    - Qualified patients are entered into the R&B database
    - Patients with no category [over assets or undocumented aliens] will be given financial counseling information and passed back to Customer Service for follow up.
- As necessary, liaison will go into the field to obtain patient information [as directed by home office, Connecticut advocates].
- A file of all patients in the R&B database will be sent monthly to Waterbury Hospital and reconciled against the hospital HIS system.
- Waterbury Hospital will receive notification as follows:
    - Acknowledgements of patients entered into database
    - Entitlements for Medicaid/Saga
    - Accounts returned for various reasons such as "patient uncooperative"
- Liaison will work closely with Patient Access, Patient Accounts and Case Management for retro-authorization by Qualadigm for Medicaid/Saga patients.
- Liaison will also work closely with WHAP program on patients with spend down and for entitlement to other services such as pharmacy benefits and food stamps.
- On a monthly basis, a file of all encounters on R&B hold will be sent to R&B for current status, highlighting high dollar cases.
    - Cases will be compared to prior month so new cases will be reflected.

- On a weekly basis, liaison will send a report of all cases worked/reviewed during the previous week, to Director, for logging purposes. Categories reported are as follows:
    - New patient accounts reviewed
    - Rechecks
    - Medicaid applications
    - Referral, no application
    - Over assets, UDA, no category
    - Insurance found, T19
    - Courtesy application
    - Payment arrangements
    - Carry over from previous week

Waterbury Hospital
CREDIT & COLLECTION MANUAL

SOURCES OF PAYMENT

CATEGORY: Credit & Collection	**POLICY: Sources of Payment**
REVIEWED:06/10	**REVISED: 01/07, 12/07,06/10**
RETIRED:	

PURPOSE: To define the various sources of reimbursement

POLICY: It is the policy of Waterbury Hospital to define and verify the payment source accurately, for each encounter.

There are several sources of payment as follows:

I. PATIENT
The primary responsibility for payment of the Encounter always rests with the patient. All patients will be required to sign a patient agreement prior to admission or at time of registration. The patient agreement contains the assignment of benefits.

In any controversy, default or misrepresentation, the hospital will always seek payment from the patient. In the event of special contract situations, workers compensation or state/federal regulation releasing patients from responsibility, payment will be sought from the appropriate third-party agent, if applicable.

Unpaid patient balances result in increases in the cost of patient care, therefore, the patient portion of the hospital bill, whether it is the full bill in the case of self-pay, or balances after insurances have paid, are to be satisfied thru one or more of the following resources:

- Cash, money orders, personal checks, travelers checks [U.S. currency]
- Credit cards acceptable to the hospital - Mastercard, Visa, Discover, American Express
- Savings Encounters, income tax refunds
- sale of investments, conversion of insurance policy
- lans from banks, credit unions, finance companies, etc.

Waterbury Hospital will request payment of co pays and/or deductibles at time of scheduling, pre-Service, point-of-service and post-service, based on eligibility determination and verification/authorization.

Self pay elective patients, which include cosmetic procedures, are required to make payment prior to service. See the specific policies governing self pay expectations.

II. THIRD-PARTY COVERAGE

Government Payors

Medicare – It is the policy of Waterbury Hospital to bill Medicare, Managed Medicare and Medicare patients per the guidelines set forth in the HIM-10 Medicare manual, and subsequent changes to policies, procedures, etc., as directed by the fiscal intermediary for Waterbury Hospital – Empire Blue Cross of New York.

Medicaid [State/City] – It is the policy of Waterbury Hospital to bill Medicaid as per the instructions set forth by the Department of Income Maintenance for the state of Connecticut.

Contracted Payors [HMOs, PPOs etc.]

It is the policy of Waterbury Hospital to bill contracted payors and patients according to the terms and guidelines set forth in contracts and payor manuals.

Other Third-Party Payors -
It is the policy of Waterbury Hospital to bill all third-party coverage as a courtesy to the patient upon validation of benefits and assignment of payment to the hospital and to abide by any prompt pay discount arrangements.

III. UNCOMPENSATED FREE CARE:

Waterbury Hospital recognizes its responsibility to those patients who are unable to pay for services rendered due to financial hardship, and who do not qualify for State or City Welfare programs. Free bed funds and other programs, are available for those patients who meet established criteria. Application can be made with Customer Service [Financial Counseling] after services are rendered.
Available programs include:

- Patient Assistance Committee - approved Encounters are put towards Free Bed Funds
- Sliding scale
- Public Act 94-9 [uninsured patients]
- Charity Care - Usually small dollar amounts that are not presented to Patient Assistance Committee for deceased/indigent patients
- Repayment contracts.
- Self pay prompt pay discount

Waterbury Hospital will cooperate with all third-party payers and patients to the fullest extent in order to facilitate the collection of all balances due.

WATERBURY HOSPITAL MEDICAL CENTER

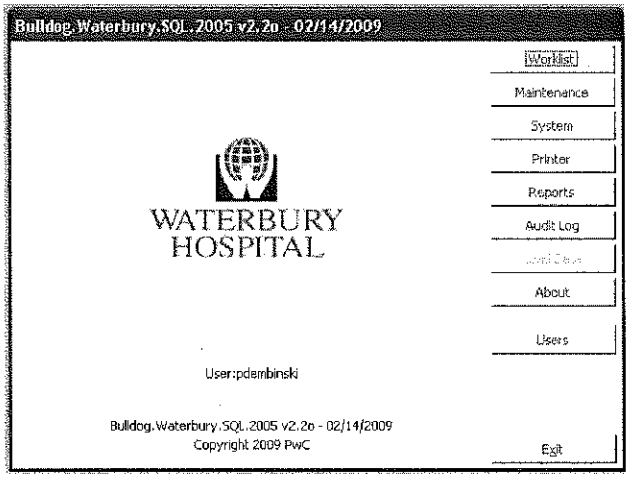
SITUATION AND RESPONSE GUIDELINES

Commercial Follow-up
All Claims Aged Greater Than
15 Days from Final Billed Date

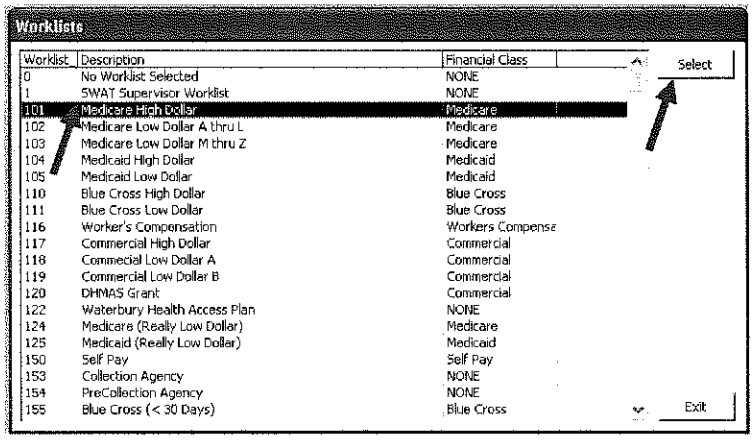
The purpose of this function is to determine claim status and obtain as much information from the payer as possible.

STEP 1: LOG INTO THE WORK LISTS MODULE THEN ACCESS THE WORK QUEUE IN THE A/R MANAGEMENT TOOL (BULLDOG)

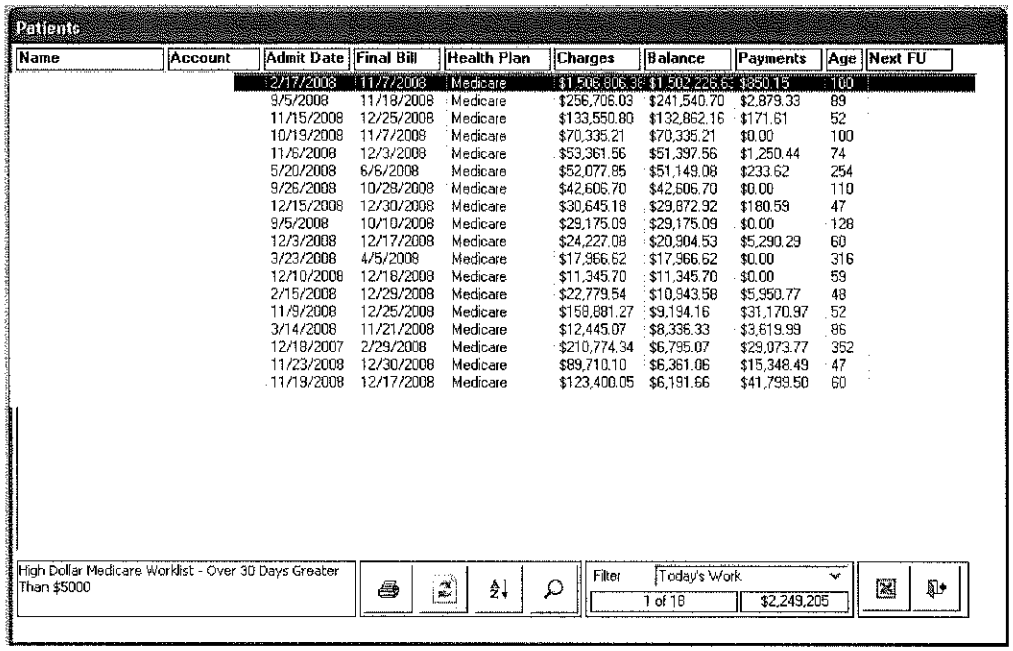
A. Click the **Worklist** button to access your individual worklist(s).



B. If responsible for multiple work lists then select the appropriate Work List.



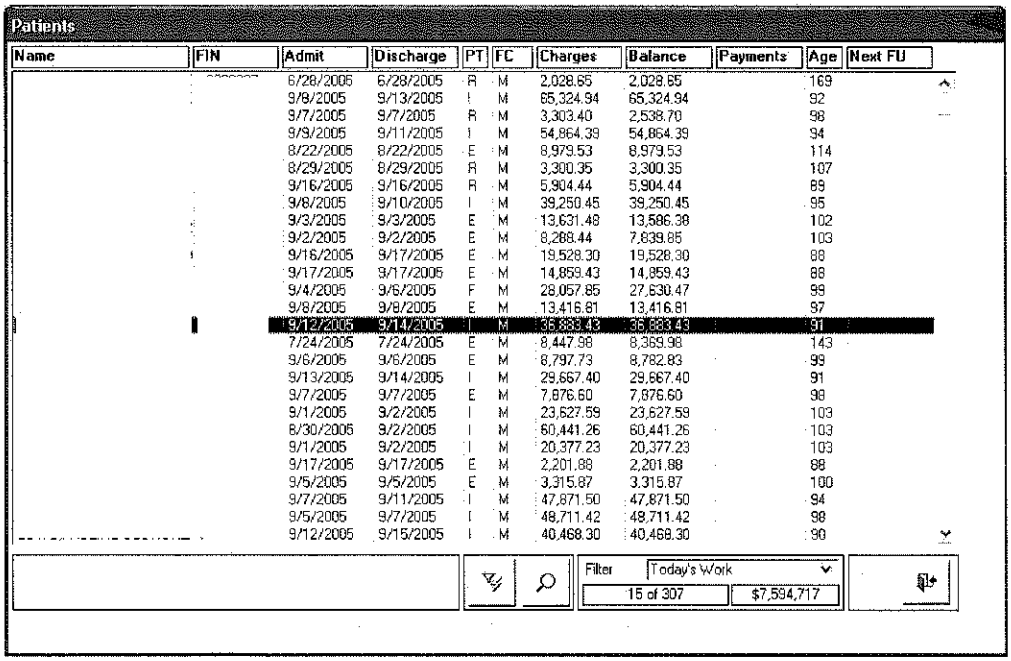
C. The selected work list will now appear in a new window.



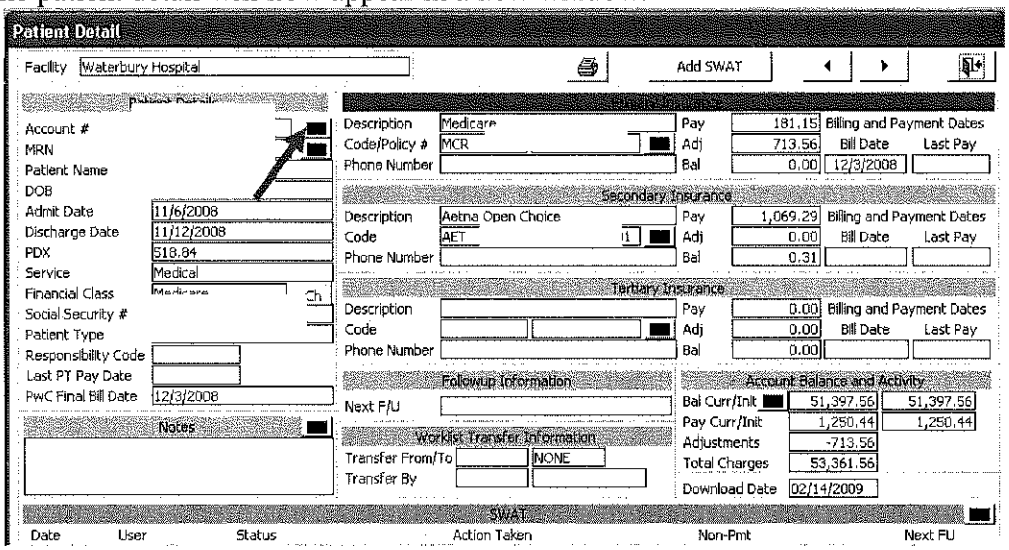
D. Select the encounter with the highest balance.

STEP 2: ACCESS THE PATIENT ENCOUNTER DETAIL WINDOW BY DOUBLE CLICKING THE ENCOUNTER IN THE WORK LIST

A. Double click on the patient encounter in the list to access the patient detail.



B. The patient detail will now appear in a new window.

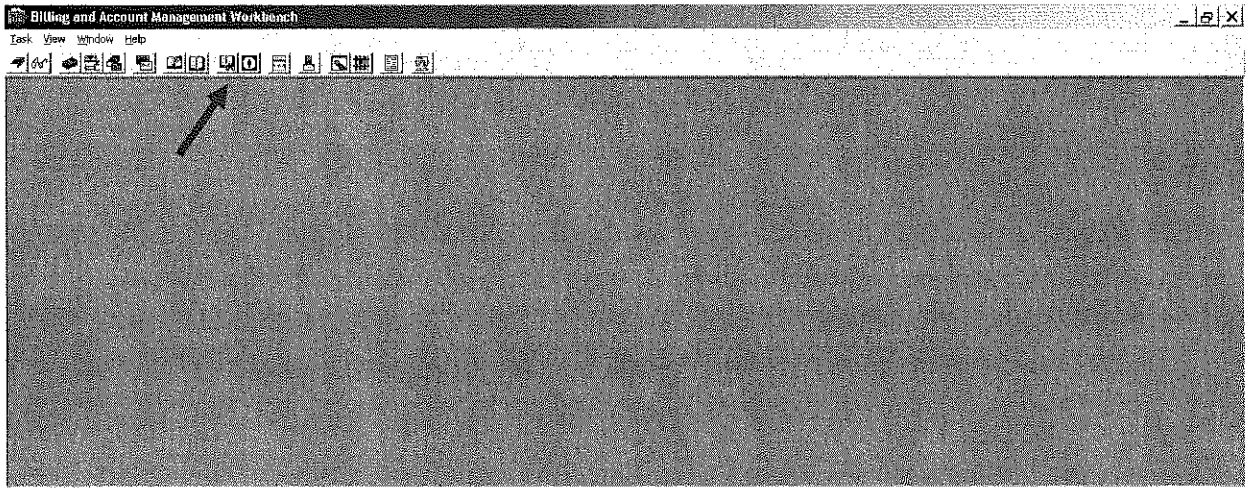


C. Click the blue box next to the Account # to copy the Cerner encounter number.

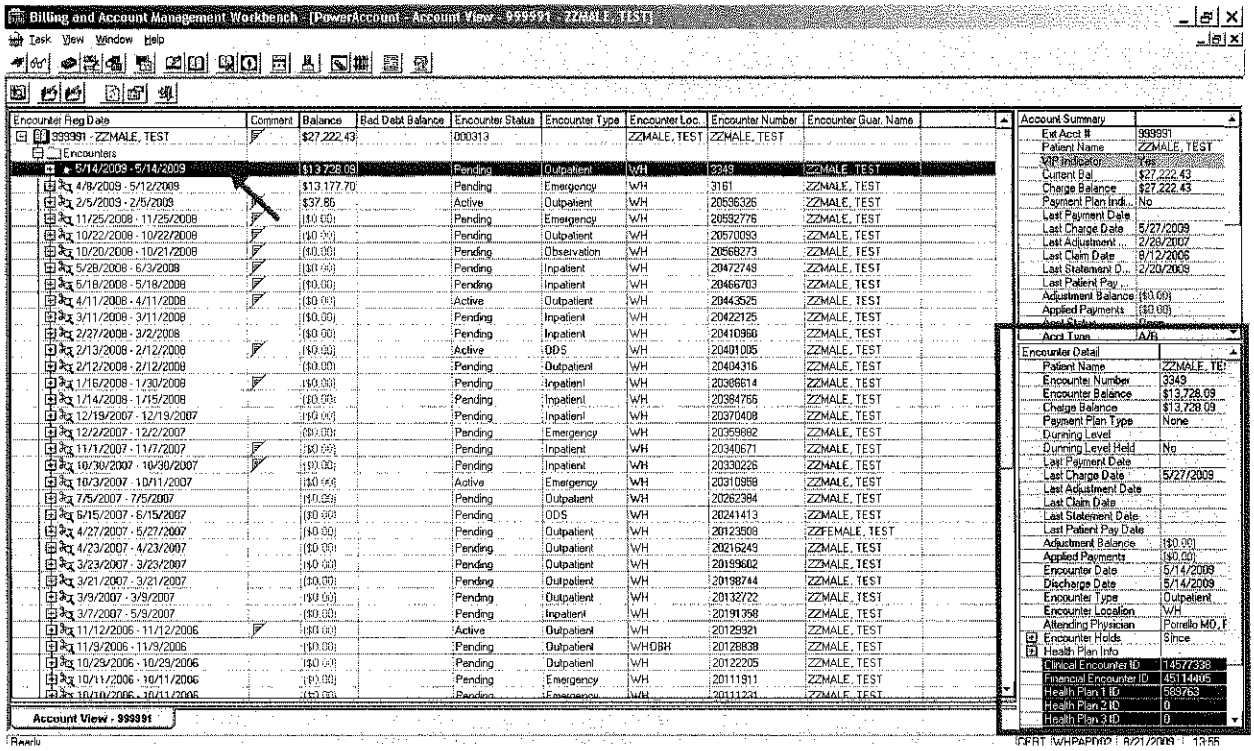
STEP 3: IDENTIFY THE PAYER AND PERTINENT PATIENT DEMOGRAPHIC INFORMATION

Please refer to the patient's insurance information located in the Encounter Detail on the lower right hand side of the Account View screen in the Patient Accounting System (Cerner).

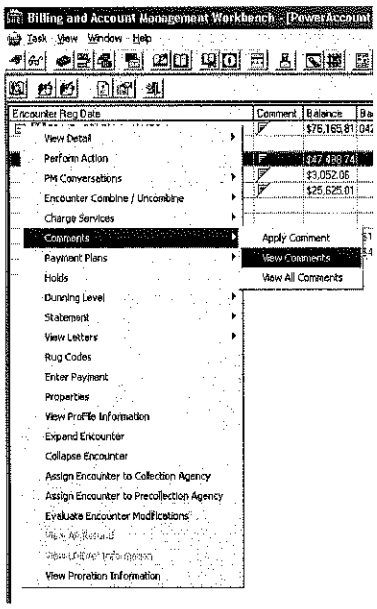
A. Open Profit PABS via the Citrix web application on the computer desktop.
B. From the opening window of Profit click the Patient Account Search icon to retrieve the encounter.



C. Right click then select paste to paste the encounter number into the FIN NBR field on the Account Search window.
D. Press Search to retrieve the encounter.
E. Double click on the patient's name to select the corresponding patient encounter in Profit.
F. The following window appears.



G. Identify the corresponding encounter in the patient record.
H. Review the patient's encounter detail on the lower right hand portion of the window to identify the following information:
    a. Full Patient Name
    b. Most Recent Encounter Balance
    c. Applied Payments(if any)
    d. Applied Adjustments (if any)
    e. Applied Encounter Holds
    f. Health Plan Information, including Payer Phone Number & Address
I. Once the pertinent encounter details have been identified right-click on the encounter, scroll to comments, followed by view all comments to read all prior account notes.
    g. Before contacting the payer make certain that you read all prior notes.



STEP 4: DETERMINE IF THE CLAIM IS DENIED/REJECTED OR IS PAST DUE

Please use this section to guide your decision making process regarding Denied / Rejected or Past Due Claims.

Note: If there is NO Denial or Rejection on the encounter please move to Step 6 - Contact the Payer

If the encounter ***is*** Denied or Rejected refer to the following process:

A. The collector will review each account in his/her work queue and will decide if further follow up action is required. Refer to the process flow (in your binder) should you need assistance regarding the lifecycle of a rejected/denied claim.
   a. Rejected or Denied encounters should either be address within the PAFS Department or routed to other Revenue Cycle Departments for assistance according to the following matrix
   b. PAFS Collectors are instructed to solicit help from other Revenue Cycle departments throughout the hospital when assistance is needed to resolve a Rejected or Denied encounter.

SITUATION 1: No Action Required

If there is no further follow up action required after initial review and there is a self pay balance, the collector will ensure the balance has moved to the self pay benefit order, confirm that all holds have been removed and the adjustment is accurate (if applicable). If there is no self pay balance then the collector will determine the

appropriate adjustment code to use either based on the guidelines set forth in the Adjustment Policy.

SITUATION 2: Yes - Action Required

If the claim requires further additional action the collector must first determine who will correct the claim.

SITUATION 2a: Encounter should be routed to another department

a. Rejected or denied encounters requiring action from another hospital department will be referred by the collector to the responsible department via email or voicemail. The request should note the FIN # and the reason why assistance is need and action may be necessary. The collector should then apply the appropriate action code in the AR Management Tool which will record a specific tickle date on the referral. The responsible department must take action within three (3) business days.
   i. If the encounter is routed back to the collector prior to the next follow-up date the collector will perform the action steps according to the department's instructions. (i.e., Adjustment, Submit Corrected Claim, etc.)
   ii. If the claim is ***NOT*** referred back within the specified time frame, the collector should call the contact person. If the collector is still unable to resolve the issue the encounter should be escalated to PAFS Management for assistance.

b. Encounters should be routed to other Revenue Cycle Departments according to the following matrix:

Department Responsible for Managing the Rejection	Referred To	Extension
Case Management	Carole Ann Whetmore	7270
Patient Access	Sherri Cianflone	7622
Behavioral Health	MaryAnne Berube	7021
OPMT / EEG / Sleep Center	Deb Terino	7081
Gastroenterology / Intestinal	Barb Lafreniere	6070
Pulmonary / Cardiology	Monica Giacomi	7108
Radiology	Robert Aviles	5859
Laboratory	Anne Lemelin	7604
HIM / Coding	Lawrence Foster	6011

SITUATION 2b: Collector responsible for correcting claim

c. If the collector has the means available to correct the rejection ***without*** the assistance of another hospital department then the collector will take the proper action steps. (i.e., Adjustment, Submit Corrected Claim, etc.)
d. Refer to **Step 5 - Situation specific responses to address rejected or denied encounters** for examples of the appropriate follow-up steps

Note: All scenarios not covered in Situation 2a (above) or the scenarios in Step 5 (below) shall be handled, analyzed and/or corrected by the PAFS Collector. If assistance is needed to resolve the encounter please escalate the situation to the Assistant Director of PAFS.

SITUATION 2c: No action possible

e. If the denial is due to no authorization, non-covered service or no ABN (Advance Beneficiary Notice) where the department states that no other action is possible use one of the approved PLC Transaction Codes to Adjust the claim.

Note: If the collector is unable to determine next steps the claim should be escalated to the Assistant Director PAFS.

Note: In all situations comments regarding the action take are REQUIRED. Please enter specific information succinctly into the AR Management Tool and Cerner as directed according to the Quality Assurance Program Guidelines. (Refer to Step 9 for specific documentation instructions)

STEP 5: Situation specific responses to address rejected or denied encounters

EXAMPLE 1: Collector reviews an encounter with a Benefits Exhausted / Deductible rejection type

Response: If benefits are exhausted or you find an applied to deductible remark, confirm that the benefit order is complete then bill the secondary (if applicable). If there is no secondary insurance move the balance to the self pay bucket. The collector should ensure all holds are removed.

EXAMPLE 2: Collector reviews an encounter with a Coordination of Benefits rejection type

Response: The collector will contact the insurance or the patient to verify the insurance information. If new insurance is obtained, updated the record, and then bill the appropriate insurance. If you are unable to obtain new insurance information advise the patient to contact their insurance carrier and ask them to call you back after they contacted the insurance carrier. If the patient fails to get back to you, transfer the balance to the self-pay bucket as the balance is now Patient Responsibility.

EXAMPLE 3: Collector reviews an encounter with a Missing Info rejection type

Response: The collector will contact the insurance company to confirm the type of information that is required. If available please provide the insurance carrier with the appropriate information. If you are unable to provide the necessary information you should contact the patient. If you are unable to obtain new insurance information advise the patient to contact their insurance carrier and ask them to call you back after they contacted the insurance carrier. If the patient fails to get back to you, transfer the balance to the self-pay bucket as the balance is now Patient Responsibility.

EXAMPLE 4: Collector reviews an encounter with an Additional Information Requested rejection type

Response: The collector will contact the insurance company to confirm the type of information that is required. If medical records are required file a request along with the insurance carriers address with the Medical Records Department. The Medical Records Department will send the records to the insurance carrier.

EXAMPLE 5: Collector reviews an encounter with a Missing Authorization rejection type

Response: The collector will review the documentation. If the authorization information is listed the collector will contact the insurance carrier. If no authorization information is listed the collector should contact the appropriate hospital department to obtain the authorization number. If the collector is unable to obtain the authorization information he/she is to use one of the approved PLC Transaction Codes to adjust the claim.

Note: All scenarios not covered in Situation 2a (above) or the scenarios in Step 5 (above) shall be handled, analyzed and/or corrected by the PAFS Collector. If assistance is needed to resolve the encounter please escalate the situation to the Assistant Director of PAFS.

STEP 6: CONTACT THE PAYER

Please use this dialogue to guide your conversation and/or inquiry with the payer.

A. Make note of the patient's demographic information in the Patient Accounting System (Cerner).

Patient Demographic Information to be Reviewed:
WH Encounter Number
WH Tax Identification Number
Patient's Name
Patient's DOB

Patient's ID Number
Patient's Group Policy Number
Date of Service

B. Take note of how you contacted the payer (e.g., via web inquiry, phone, direct system access). If contacting the payer via phone be sure to request and record the Payer Rep's Name in the notes along with the phone number dialled.

*This information MUST be entered in the Comments Section of the Patient Accounting System in order to received credit in the Quality Assurance Program.

C. Begin the conversation with the following dialogue:

Hello (Payer Rep's Name), my name is (WH Rep's Name) with Waterbury Hospital. I am calling to determine the status of Account Number (WH Account Number X).

STEP 7: USE THE FOLLOWING SITUATION-SPECIFIC RESPONSES TO NAVIGATE INQUIRIES TO THE PAYER

A. Once connected with the Payer Rep, determine the status of the claim.

B. When determining the status of an encounter the collector should determine and/or record responses to following questions:
   a. Who the collector spoke to?
   b. What was the phone number dialled? Or method of inquiry?
   c. Where is the claim in the life cycle? Paid? Denied? In-process?
   d. When is the expected pay/check release date?
   e. Why: Document why the claim is denied; the claim has not been adjudicated; there is a delay in payment; etc.

SITUATION 1: CLAIM NOT RECEIVED

Response: Depending on the method used for confirmation of claim at Day 15, select the appropriate scenario to guide your conversation with the payer:

Confirmation Method	Response to Payer Rep
Electronic/Website	"Per (Payer) Website the following information was obtain" (List out the responses to the 5 W's Used)
Telephone	"Per Call to (Payer Name) the following information was obtain" (List out the responses to the 5 W's Used)

If claim is not found verify the policy ID# the claim was billed under. If correct, regenerate the claim in Cerner. If the information is different, update the record and re-bill the claim in Cerner.

Action Taken: Document the action taken in Cerner and record the next follow-up date based on the action code applied.

If necessary refer to step 5: Rebill Claim When Appropriate

SITUATION 2: CLAIM IS PROCESSING

Response: "This claim has been pending for since (Enter date). When do you expect to issue a payment?"

Situation 1: If the representative is unable to provide an expected payment date, ask to speak with a Claim Adjudication Supervisor.

Response: "Ma'am/Sir, (Payer Rep's Name) just indicated that (Claim Number) is still pending. Can you please provide a reason for the delay? Do you need additional information from Waterbury Hospital to process the claim?"

Situation 2: The representative indicates that processing requires additional documentation (e.g. Medical Records or Authorization Number).

Type of Request	Response:
Medical Records	"Per insurance carrier Medical Records are required. Filed request with Medical Records Department to send MRs."
Authorization Issue / # of Days	"Per insurance carrier (no auth is on file / days do not match), contacted Central Registration / Case Management for assistance."

Action Taken: Verify the authorization number matches the number on file in ERM. If not, refer the encounter to the appropriate hospital department to obtain the appropriate authorization for this encounter.

Action Taken: Document the referral request in Cerner. Be sure to reference the Name and Title of the person the encounter was referred to.

SITUATION 3: NO SPECIFIC REASON FOR THE DELAY

Response: "Given the delay in processing, can you please expedite? When can we expect payment?"

Situation: For clean claims pending 45 days or more with Contracted Payers **ONLY**, Rep will ask the payer for the interest amount.

Response: Since this clean claim is pending for more than 45 days, I will be rebilling this claim today to reflect the Clean Claim Interest Charge.

Action Taken: Document the rebill action and the application of interest charges then rebill claim.

Refer to Step 5: Rebill the claim

SITUATION 4: PAYER REQUIRES ADDITIONAL DOCUMENTATION (OR MEDICAL RECORDS)

Response: "Thank you (Payer Rep's Name). Can you please tell me who I should send the medical records to, including a specific contact name and address?"

Action Taken: Document the medical records request, indicate who you sent the request to and then send the medical records request using the appropriate form.

SITUATION 5: CLAIM IS PROCESSED AND PAID

Response: "Thank you (Payer Rep's Name). Can you please provide me with the following information: ___?"

- Claim Number
- Batch Number or Check Number
- Batch Date or Check Date
- Mailed Date (if applicable)
- Amount Paid
- Mailing Address (if available)

Confirm mailing address if payer makes check payments (Refer to Part B below).

SITUATION 6: CLAIM IS PAID / PAYER INDICATES EFT TRANSFERRED OR CHECK CASHED

Response: "Thank you (Payer Rep's Name). Can you please provide me with the following information:"

- Claim Number
- Check Date
- Total Amount of Check

- Mailing Address (if available)
- The name of another patient paid via the same check
- Copy of the cancelled check (if available)

Response: "We do not have record of receiving/cashing this payment. Can you please double check your records. Additionally, can you please provide me with (batch number or fax a copy of the Cancelled Check Copy to my attention at Fax Number) for further research."

Action Taken: Once received the collector should send and email to the Cash Posting Supervisor to request Unapplied Cash Research.

Action Taken: Confirm mailing address if payer makes check payments.

C. Before ending the call, be sure that you have answered and documented the necessary items in step 4 bullet point B (above).

Remember encounter inquiries are considered productive if they have the following characteristics:

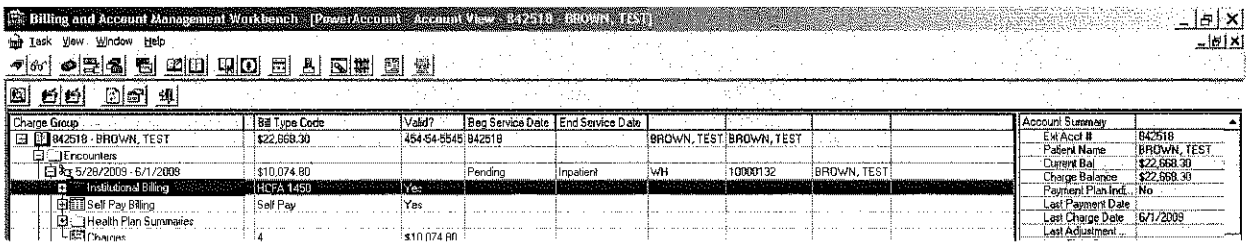
i. Quality data is in the account note
ii. The note is Readable (for examples please refer to the Readability and Appropriateness of Action Examples document) to someone outside of PAFS
iii. The Appropriate Action was taken to resolve or move the Account Forward

STEP 8: REBILL CLAIMS WHEN APPROPRIATE

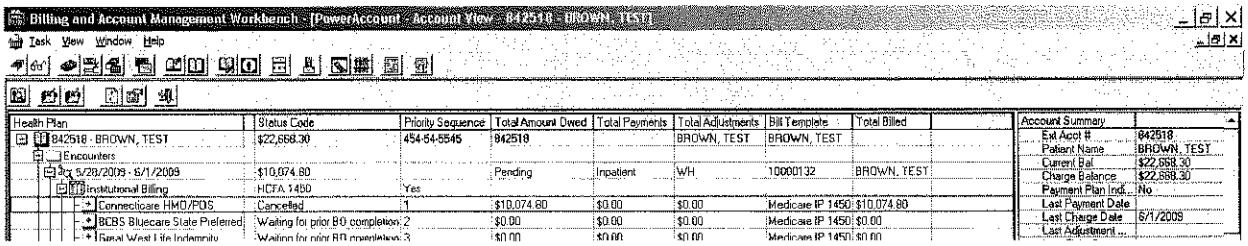
SITUATION 1: REBILL CLAIMS ELECTRONICALLY

STEPS TO REBILL CLAIM ELECTRONCIALLY:

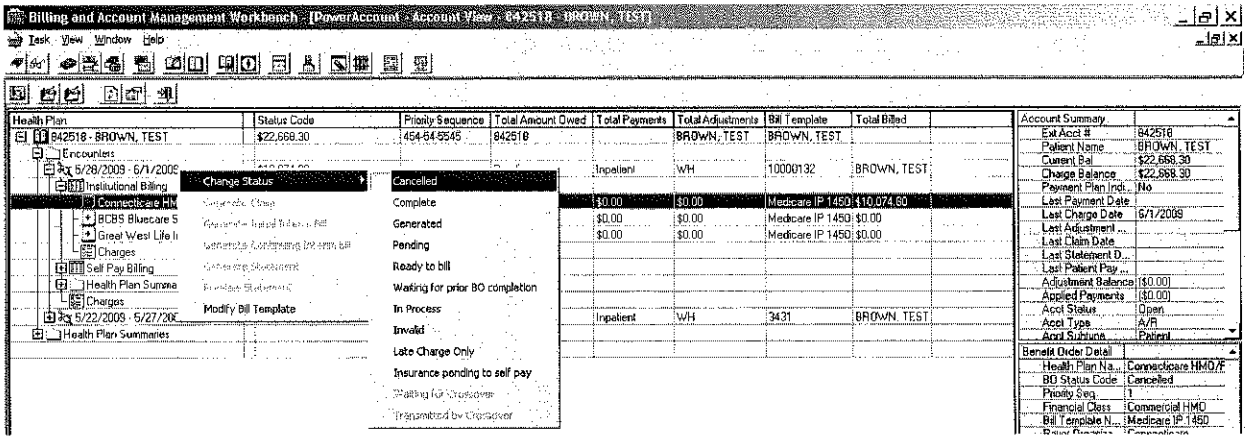
1. From the Power Accounts, select **the encounter** you wish to rebill then drill down to the appropriate billing component by clicking the + box next to the encounter.



2. Open the highlighted claim and click on institutional billing.



3. Highlight the transmitted claim, right-click and click CANCEL then REFRESH your screen.



4. A new claim will be forwarded to SSI or PcACE when the next billing cycle begins.

SITUATION 2: RESUBMIT CLAIMS VIA USPS MAIL

Response: "I will mail another copy of the claim to you today via US Mail. What address should I send this claim to? Additionally, to whose attention should this be sent? I will be calling again in 10 days to confirm receipt."

Action Taken: Refer to Steps 1-4 in Situation 1 (above).

STEP 9: ESCALATE PRIORITY ACCOUNTS PER ESCALATION GUIDELINES (IF NECESSARY)

It is the obligation of the PAFS Collectors to press third party payers for reimbursement on all Past Due and Denied claims. At a minimum the collector should make three (3) distinct collection (reimbursement) attempts with the third party payer before escalating an encounter.

Follow these instructions when escalating encounters:

1. The PAFS Collector shall begin making collection calls 15 days from the Final Bill Date.

- The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.
- Based on the outcome of the initial follow-up phone call the PAFS Collector shall set a specific follow-up date using the Action Code Functionality in the patient accounting work driver.

2. If the encounter is still unresolved after two (2) phone calls to the payer the PAFS Collector shall request to speak with a Claim Adjudication Supervisor.
    - The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.
    - Based on the outcome of the second follow-up phone call the PAFS Collector shall set a specific follow-up date using the Action Code Functionality in the patient accounting work driver.
3. If the encounter remains unresolved after three (3) phone calls to the payer and escalation to the Claim Adjudication Supervisor the PAFS Collector shall notify the Assistant Director of Patient Accounting via email that the patient claim is severely past due.
    - The collector shall document this internal escalation request in the Patient Record in the Patient Accounting System.
4. Immediately after notifying the Assistant Director of Patient Accounting that the encounter is past due the PAFS Collector shall notify the patient or the patient's estate, when possible, of their contracted designee's failure to adjudicate their claim.
    - The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.
5. At this time the Assistant Director of Patient Accounting will document the encounter in the escalation log (attached) and will inform the PAFS Collector that the encounter needs to be escalated to the Payer Contract Representative or Account Manager via the payer preferred method of inquiry (e.g., email, phone call, BCBC Past Due Workbook, etc.).
    - The collector shall document this escalation inquiry and record notes in the Patient Record in the Patient Accounting System.
6. If the encounter remains unresolved after two (2) escalation attempts with the Payer Contract Representative or Account Manager the PAFS Collector shall follow-up with the Assistant Director of Patient Accounting.

ACCOUNTS REQUIRING ESCALATION TO ASSISTANT DIRECTOR OF PATIENT ACCOUNTING
<u>High Dollar Accounts</u> Unresolved patient accounts with balances greater than $10,000 aged 60 days or greater from the final billed date (90 days or greater for Medicaid and SAGA) must be escalated to the Assistant Director of Patient Accounting after three (3) call attempts.
<u>Unresolved accounts</u> All accounts that require action from another revenue cycle department that have been forwarded to the appropriate department on at least one occasion and have not received a response within three (3) days.

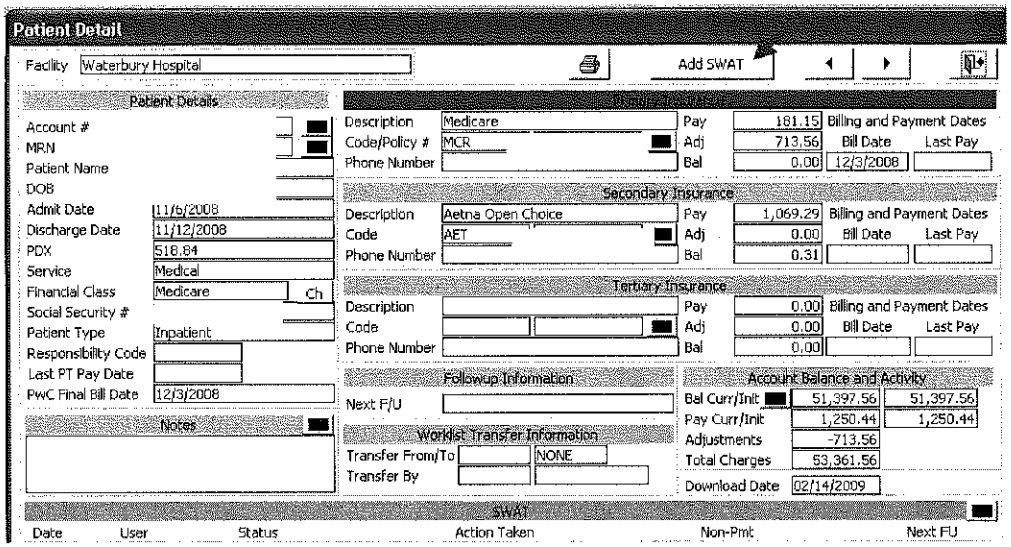
Note: If the hospital is to receive prompt payment from third parties, it is important that the initial billing statement to the third party be prompt, accurate, and clear. Reimbursements can

be justifiably delayed if the required forms, medical information, and/or signatures are not provided to the third party payer.

STEP 10: DOCUMENT THE FOLLOW-UP ACTION AND ENTER AN ACTION CODE IN THE A/R MANAGEMENT TOOL AND THE PATIENT ACCOUNTING SYSTEM

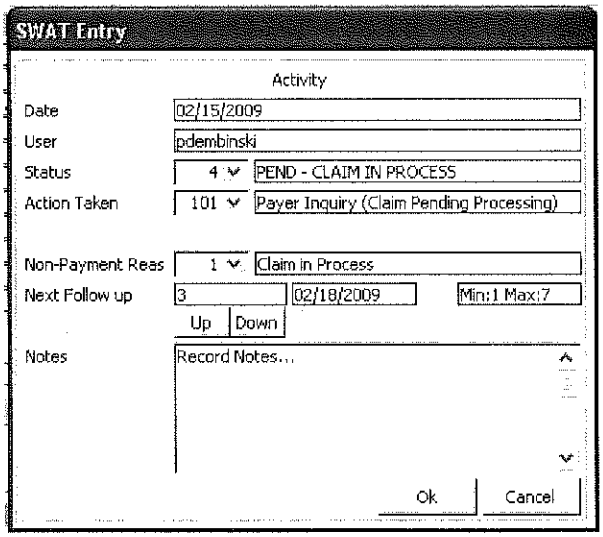
Document all information obtained from the payer inquiry in the Comments Section of the A/R Management Tool and the Patient Accounting System (Cerner).

A. Return the Patient Detail window in the A/R Management Tool
B. Click Add SWAT



Note: The SWAT Button: allows the patient account representative to enter an action code and pend the account for a later follow-up date.

C. The following window appears:



D. You will be required to enter three distinct action codes in the SWAT Entry Screen

a. Status Code

Status Definitions

0	None
1	PEND - ADJUSTMENT
2	PEND - APPEAL IN PROCESS
3	PEND - AUTH/REFERRAL RESEARCH
4	PEND - CLAIM IN PROCESS
5	PEND - CODING REVIEW
6	PEND - INVOICE REQUEST
7	PEND - MEDICAL RECORDS
8	PEND - PAID/BALANCE IS LATE CHARGE
9	PEND - UPDATING INFORMATION
10	PEND - SPLIT BILL
11	PEND - CORRECTED CLAIM
12	CLOSED - NON-COVERED SRVC/TRANSFERRED TO PATIENT
13	CLOSED - NOT PRIMARY INSURANCE
14	CLOSED - BALANCE TRANSFERRED TO PATIENT
15	CLOSED - WRITTEN OFF

b. Action Taken Code

Action Taken Definitions

ID	Description
1	Supervisor - Transfer Back To User
101	Payer Inquiry (Claim Pending Processing)
102	Billed Another Insurance as Primary
103	Billed other Insurance
104	Called Pt - Left Message
105	Coding/ HIM Issue
106	Corrected Claim
107	Faxed Information to Payer
108	Filed Paper Appeal
109	Medicare Overlap

110	Corrected Claim Online
111	Requested Adjustment
112	Requested Charges to Be Moved
113	Requested Medical Records
114	Requested Payment Transfer
115	Resubmitted Claim with Medical Records/EOB
116	Resubmitted Claim with Appeal Letter
117	Resubmitted Claim
118	Resubmitted Late Charges
119	Sent Letter To Patient Requesting Information
120	Request Supervisor Review
121	Zero Balance

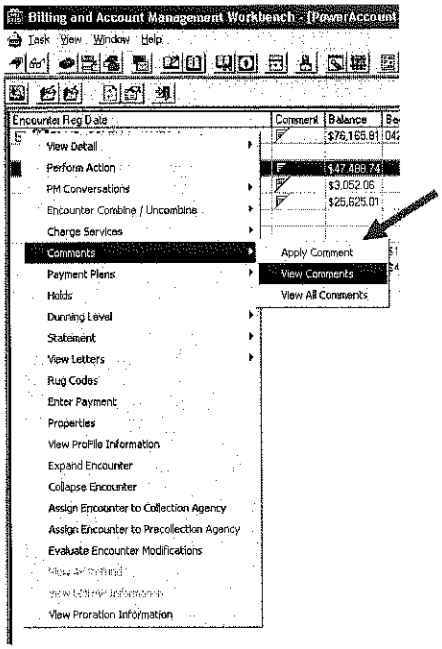
c. Non Payment Reason Code

Non Payment Reason Definitions

ID	Description
0	None
1	Claim in Process
2	Claim Not on File
3	COB Issue
4	Duplicate Claim
5	Eligibility / Enrollment / Subscriber
6	Late Charges
7	Maximum Benefits
8	Medical Necessity
9	Needs Adjustment
10	Non-covered Service
11	Overlapping Claim
12	PAID
13	Precert / Authorization
14	Pre-Existing Condition
15	Timely Filing
16	MVA/Liability Case

d. A note is also required in this field
    i. The note can be copied from the A/R Management Tool by clicking the blue button in the SWAT Entry Screen

E. Once all the fields have been properly filled out, then click the "Okay" button. A receipt of the SWAT will appear in the audit trail window at the bottom of the main Patient Detail screen.
F. Return to patient encounter in Profit.
G. Right-click on the encounter scroll to comments, then select Apply Comment.



H. In the new window either paste or re-key the note which documents the results of the payer inquiry.

Again, remember, encounter inquiries are considered productive if they have the following characteristics:

i. Quality data is in the account note
ii. The note is Readable (for examples please refer to the Readability and Appropriateness of Action Examples document) to someone outside of PAFS
iii. The Appropriate Action was taken to resolve or move the Account Forward

Note: The following examples are considered to be acceptable according to the documentation standards noted in the Waterbury Hospital QA Program.

Claim Not Received:

Per (Payer Rep's Name) at (Payer Name & Phone Number), claim was not received. (Re-billed/re-sent) the claim via (Method of Submission, Indicate Fax Number or Address, if applicable) on (Date).

For Checks ONLY:
Confirmed the address on record.

Claim Processing:

Needs Additional Documentation:

Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) still processing. Per Supervisor, (Supervisor's Name), requested additional documentation (Indicate which). Referred account to (Indicate which) department requesting documentation.

No Additional Documentation Needed:

Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) still processing. Requested to speak with a Supervisor. Supervisor, (Supervisor's Name), indicated that claim still processing. Asked Supervisor to expedite processing given the delay.

Claim Processed/Paid:

Sent to Correct Mailing Address:

Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date).

For Checks ONLY:

Confirmed that payment was sent to the correct mailing address.

Sent to Incorrect Mailing Address:

Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date).

For Checks ONLY:

The payer had the incorrect mailing address on file. (Payer Name)'s corrected the address and reprocessed the claim. Also requested that payer stop payment for the original check. Expect payment in (Days).

Claim Processed/Paid/Cashed:

Sent to Correct Mailing Address:

Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date).

For Checks ONLY:

Confirmed that the payment was sent to the correct address. Requested a copy of the cancelled check to initiate research. Will be faxed to my attention.

Sent to Incorrect Mailing Address:

Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date). The Payer had the incorrect address on file. Therefore, I informed her/him of the correct address and asked for the claim to reprocessed. Also requested that payer stop payment on the original check. Expect payment in (Days).

WATERBURY HOSPITAL MEDICAL CENTER

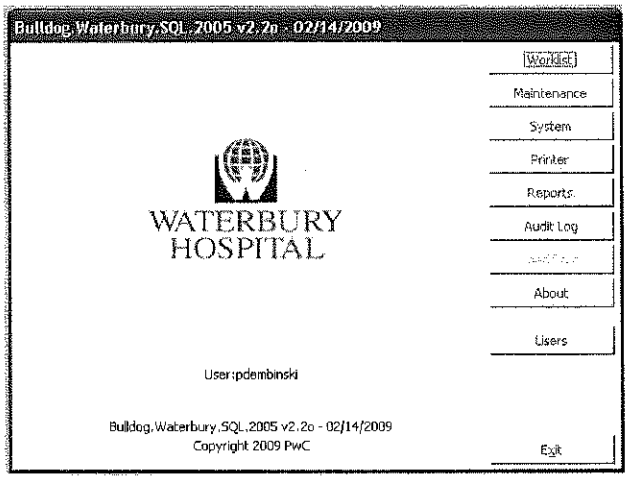
SITUATION AND RESPONSE GUIDELINES

Medicare Follow-up
All Claims Aged Greater Than
15 Days from Final Billed Date

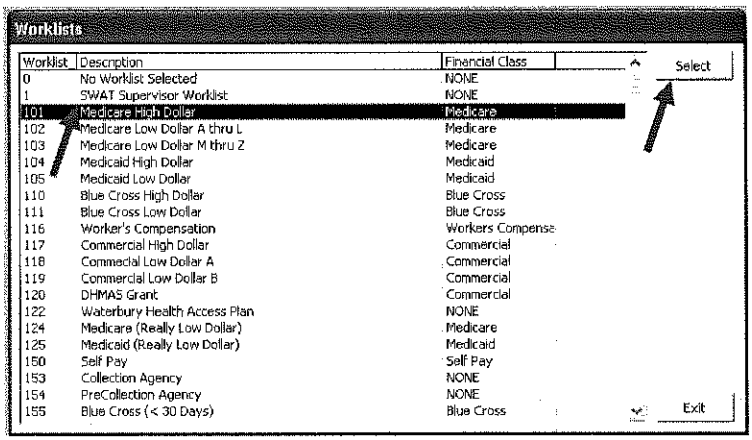
The purpose of this function is to determine claim status and obtain as much information from the payer as possible.

STEP 1: LOG INTO THE WORK LISTS MODULE THEN ACCESS THE WORK QUEUE IN THE A/R MANAGEMENT TOOL (BULLDOG)

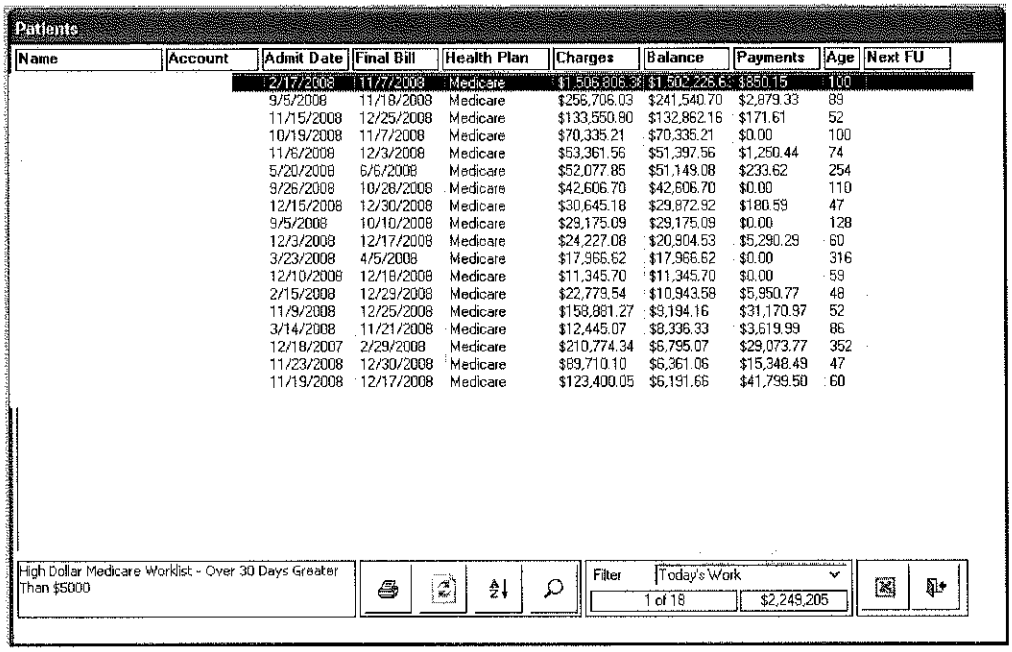
A. Click the **Worklist** button to access your individual worklist(s).



B. If responsible for multiple work lists then select the appropriate Work List.



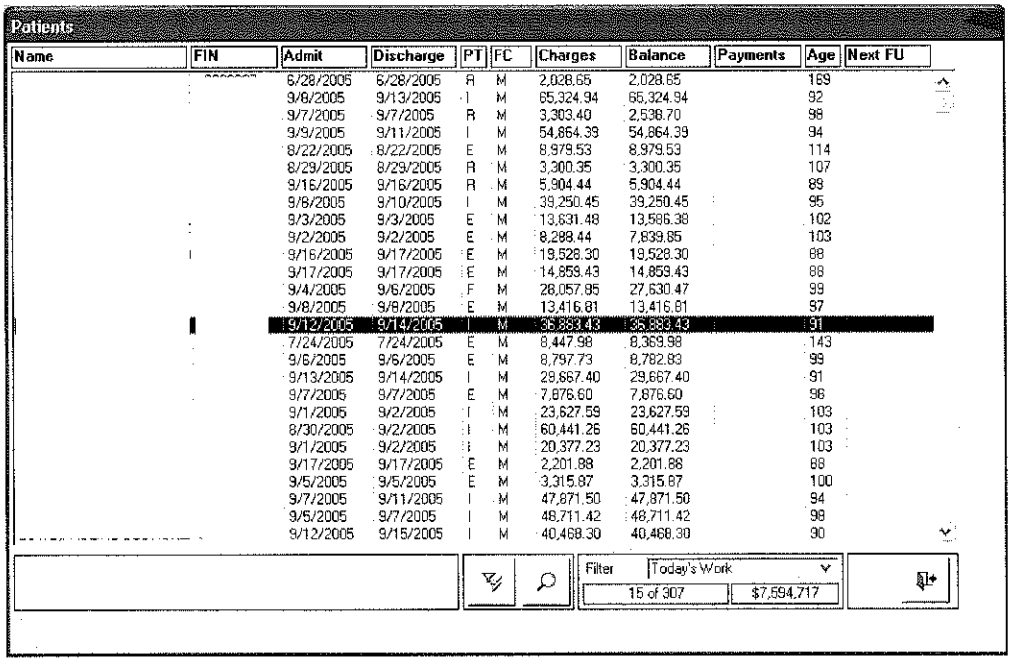
C. The selected work list will now appear in a new window.



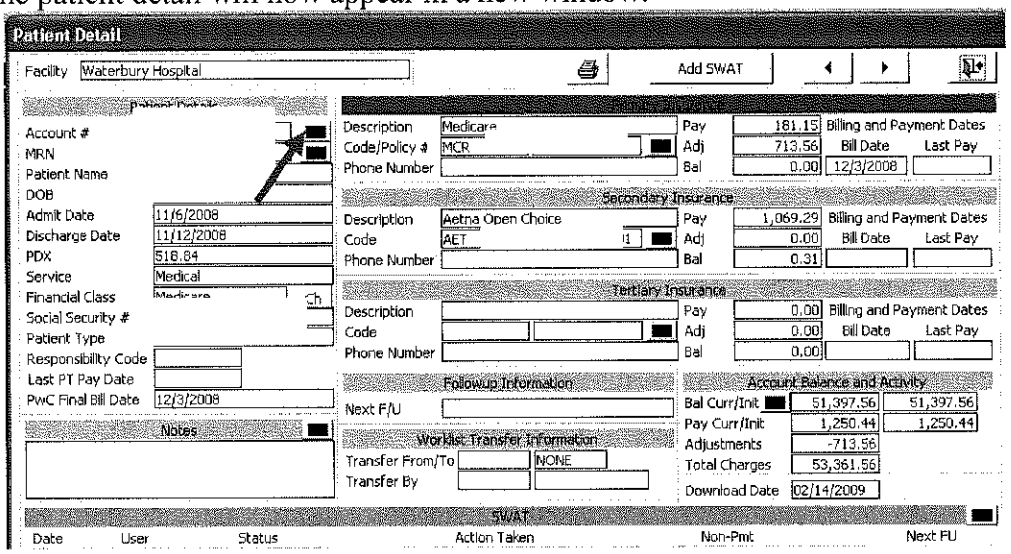
D. Select the encounter with the highest balance.

STEP 2: ACCESS THE PATIENT ENCOUNTER DETAIL WINDOW BY DOUBLE CLICKING THE ENCOUNTER IN THE WORK LIST

A. Double click on the patient encounter in the list to access the patient detail.



B. The patient detail will now appear in a new window.

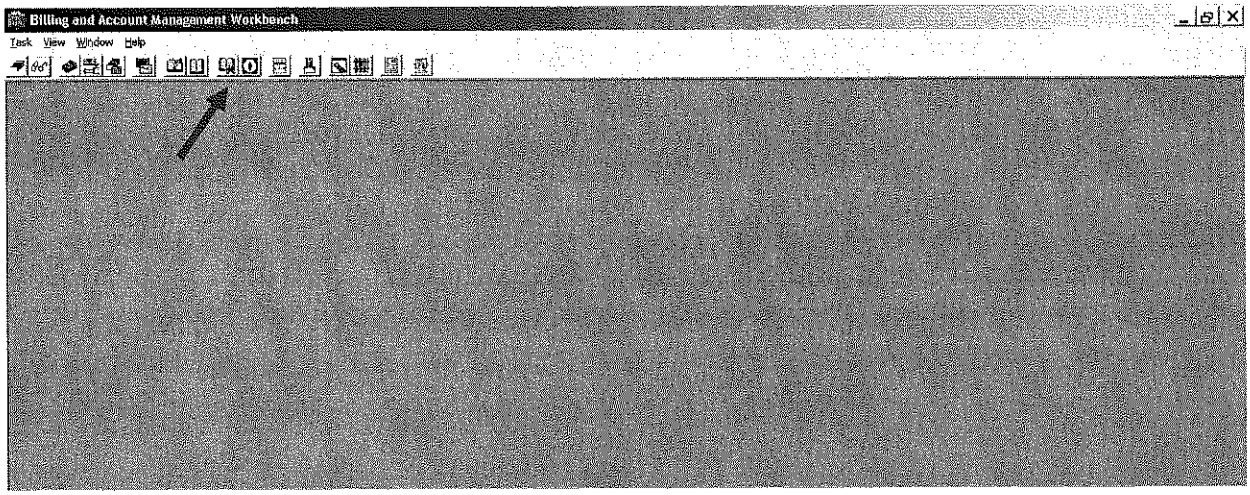


C. Click the blue box next to the Account # to copy the Cerner encounter number.

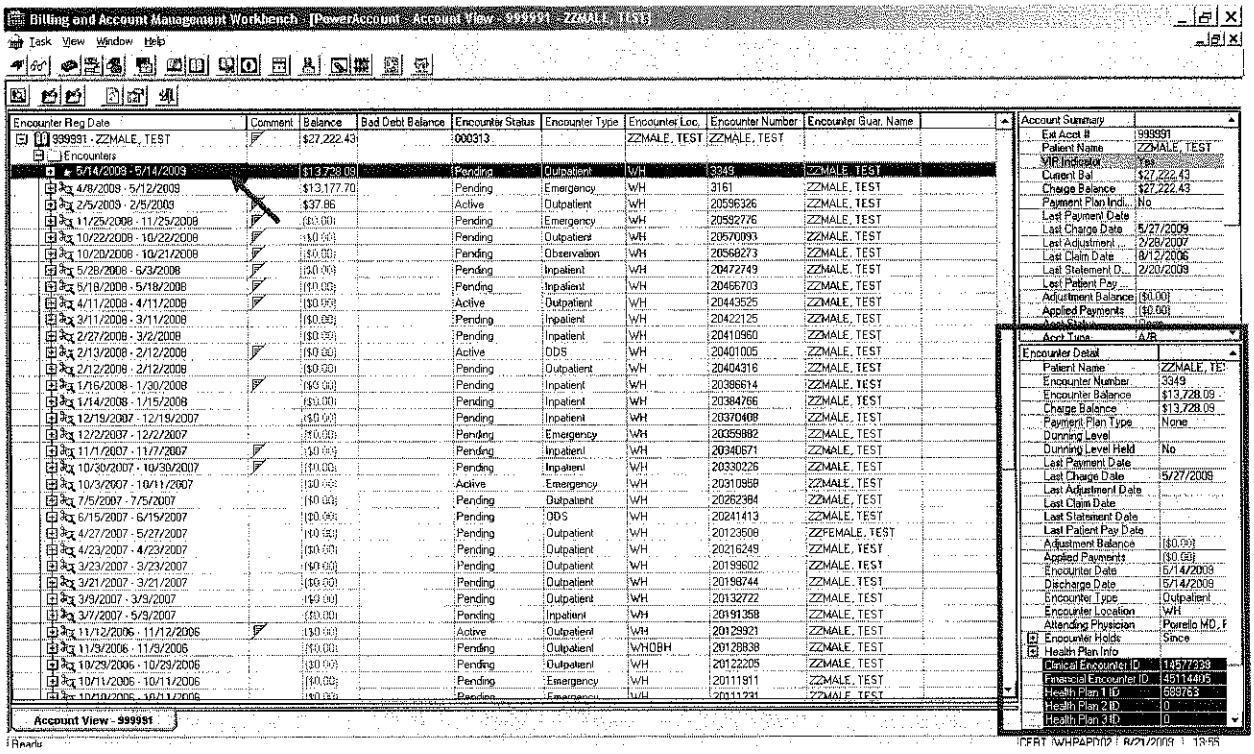
STEP 3: IDENTIFY THE PAYER AND PERTINENT PATIENT DEMOGRAPHIC INFORMATION

Please refer to the patient's insurance information located in the Encounter Detail on the lower right hand side of the Account View screen in the Patient Accounting System (Cerner).

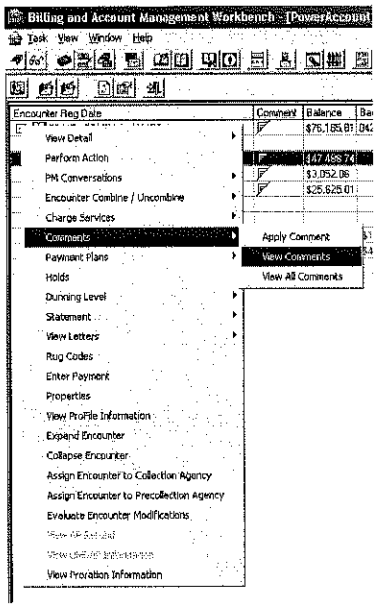
A. Open Profit PABS via the Citrix web application on the computer desktop.
B. From the opening window of Profit click the Patient Account Search icon to retrieve the encounter.



C. Right click then select paste to paste the encounter number into the FIN NBR field on the Account Search window.
D. Press Search to retrieve the encounter.
E. Double click on the patient's name to select the corresponding patient encounter in Profit.
F. The following window appears.



G. Identify the corresponding encounter in the patient record.
H. Review the patient's encounter detail on the lower right hand portion of the window to identify the following information:
    a. Full Patient Name
    b. Most Recent Encounter Balance
    c. Applied Payments(if any)
    d. Applied Adjustments (if any)
    e. Applied Encounter Holds
    f. Health Plan Information, including Payer Phone Number & Address
I. Once the pertinent encounter details have been identified right-click on the encounter, scroll to comments, followed by view all comments to read all prior account notes.
    g. Before contacting the payer make certain that you read all prior notes.



STEP 4: DETERMINE IF THE CLAIM IS DENIED/REJECTED OR IS PAST DUE

Please use this section to guide your decision making process regarding Denied / Rejected or Past Due Claims.

Note: If there is NO Denial or Rejection on the encounter please move to Step 6 - Contact the Payer

If the encounter ***is*** Denied or Rejected refer to the following process:

A. The collector will review each account in his/her work queue and will decide if further follow up action is required. Refer to the process flow (in your binder) should you need assistance regarding the lifecycle of a rejected/denied claim.
   a. Rejected or Denied encounters should either be address within the PAFS Department or routed to other Revenue Cycle Departments for assistance according to the following matrix
   b. PAFS Collectors are instructed to solicit help from other Revenue Cycle departments throughout the hospital when assistance is needed to resolve a Rejected or Denied encounter.

SITUATION 1: No Action Required

If there is no further follow up action required after initial review and there is a self pay balance, the collector will ensure the balance has moved to the self pay benefit order, confirm that all holds have been removed and the adjustment is accurate (if applicable). If there is no self pay balance then the collector will determine the

appropriate adjustment code to use either based on the guidelines set forth in the Adjustment Policy.

SITUATION 2: Yes - Action Required

If the claim requires further additional action the collector must first determine who will correct the claim.

SITUATION 2a: Encounter should be routed to another department

a. Rejected or denied encounters requiring action from another hospital department will be referred by the collector to the responsible department via email or voicemail. The request should note the FIN # and the reason why assistance is need and action may be necessary. The collector should then apply the appropriate action code in the AR Management Tool which will record a specific tickle date on the referral. The responsible department must take action within three (3) business days.
   i. If the encounter is routed back to the collector prior to the next follow-up date the collector will perform the action steps according to the department's instructions. (i.e., Adjustment, Submit Corrected Claim, etc.)
   ii. If the claim is ***NOT*** referred back within the specified time frame, the collector should call the contact person. If the collector is still unable to resolve the issue the encounter should be escalated to PAFS Management for assistance.

b. Encounters should be routed to other Revenue Cycle Departments according to the following matrix:

Department Responsible for Managing the Rejection	Referred To	Extension
Case Management	Carole Ann Whetmore	7270
Patient Access	Sherri Cianflone	7622
Behavioral Health	MaryAnne Berube	7021
OPMT / EEG / Sleep Center	Deb Terino	7081
Gastroenterology / Intestinal	Barb Lafreniere	6070
Pulmonary / Cardiology	Monica Giacomi	7108
Radiology	Robert Aviles	5859
Laboratory	Anne Lemelin	7604
HIM / Coding	Lawrence Foster	6011

SITUATION 2b: Collector responsible for correcting claim

c. If the collector has the means available to correct the rejection ***without*** the assistance of another hospital department then the collector will take the proper action steps. (i.e., Adjustment, Submit Corrected Claim, etc.)
d. Refer to **Step 5 - Situation specific responses to address rejected or denied encounters** for examples of the appropriate follow-up steps

Note: All scenarios not covered in Situation 2a (above) or the scenarios in Step 5 (below) shall be handled, analyzed and/or corrected by the PAFS Collector. If assistance is needed to resolve the encounter please escalate the situation to the Assistant Director of PAFS.

SITUATION 2c: No action possible

e. If the denial is due to no authorization, non-covered service or no ABN (Advance Beneficiary Notice) where the department states that no other action is possible use one of the approved PLC Transaction Codes to Adjust the claim.

Note: If the collector is unable to determine next steps the claim should be escalated to the Assistant Director PAFS.

Note: In all situations comments regarding the action take are REQUIRED. Please enter specific information succinctly into the AR Management Tool and Cerner as directed according to the Quality Assurance Program Guidelines. (Refer to Step 9 for specific documentation instructions)

STEP 5: Situation specific responses to address rejected or denied encounters

EXAMPLE 1: Collector reviews an encounter with a Benefits Exhausted rejection type

Response: If a secondary insurance exists, drop the balance to the secondary payer. If there is no secondary payer, drop the balance to self-pay. If dropping the balance to self-pay the collector should ensure all holds are removed and the adjustment is correct. ****Exception: If this is an IP encounter a 121 Bill must be filed for Part B benefits.***

EXAMPLE 2: Collector reviews an encounter with a Coordination of Benefits rejection type

Response: The collector will contact the insurance, employer or the patient to verify the insurance information. If new insurance information is obtained, update the encounter with the appropriate insurance. If the insurance does not change drop the balance to self-pay. If the original insurance is correct ask the patient to contact the insurance carrier and call you back. If the patient fails to get back to you, transfer the balance to the self-pay bucket as the balance is now Patient Responsibility.

EXAMPLE 3: Collector reviews an encounter with a Missing Info rejection type

Response: The collector will contact the insurance company to confirm the type of information that is required. If available please provide the insurance carrier the appropriate information. If you are unable to provide the necessary demographic information you should contact the patient. Ask the patient to contact their insurance carrier to supply the information and call you back. If the patient fails to get back to you, transfer the balance to the self-pay bucket as the balance is now Patient Responsibility.

EXAMPLE 4: Collector reviews an encounter with an Additional Information Requested rejection type

Response: The collector will contact the insurance company to confirm the type of information that is required. If medical records are required file a request along with the insurance carriers address with the Medical Records Department. The Medical Records Department will send the records to the insurance carrier.

EXAMPLE 5: Collector reviews an encounter with a Missing Authorization / Denied Days rejection type

Response: The collector will review the documentation from the registration department. If there is no registration information on file, contact the appropriate hospital department. If the authorization number is incorrect or missing, request the authorization number from the registrar. If the registrar provides the authorization information update the record in Cerner, then re-bill the appropriate insurance

Note: If assistance is needed to resolve the encounter or if there is no response received from another department please escalate the situation to the Assistant Director of PAFS or the Director of PAFS in the assistant's absence.

STEP 6: ACCESS THE NGS FISS/DDE SYSTEM

Please use these steps as your guide for access the NGS FISS/DDE System.

1. Access the Medicare FSS/DDE System via the link on your computer's desktop.
2. Key in your 'RACF Log On ID' in the Userid field.
3. Key in your 'Password' and press 'Enter'
4. At the TPX Menu select the appropriate 'Sessid'.

5. Tab to the column in front of the appropriate 'Sessid' and choose from one of the following options:

    a. For Part A Applications:
        i. FSSPCNA J13 CT/NY Part A Prod
        ii. FSSPCNA2 J13 CT/NY Part A Prod
        iii. FSSPCNA3 J13 CT/NY Part A Prod
        iv. FSSPCNA4 J13 CT/NY Part A Prod
    b. For Part B Applications:
        i. MCSPCTB J13 CT Part B Prod
        ii. MCSPCTB2 J13 CT Part B Prod
        iii. MCSPCTB3 J13 CT Part B Prod
        iv. MCSPCTB4 J13 CT Part B Prod

Note:
Multiple sessions are available for each application and may be used simultaneously to perform different functions.

6. Key an 'S' and press 'Enter'.

    a. For Part A Providers: Key **FSS0** (where 0 is number) and press 'Enter'.

    b. For Connecticut Part B Providers: Enter the following command: **SBCT,CLERKID,P,MENU** (where the CLERKID is your PPTN ID).

STEP 7: NAVIGATE THE CLAIM SUMMARY INQUIRY SCREEN

A. Once you have accessed the FISS/DDE System select Option '12' from the Inquiry Menu to access the Claim Summary Inquiry Screen.

B. Determine the status of the claim:

    a. The Claims Summary Inquiry screen displays specific claim history information for all pending (RTP claims, MSP claims, Medical Review claims) and processed (paid, rejected, denied) claims.

    b. The claim status information is available on-line for viewing immediately after the claim is updated/entered on DDE. The entire claim (six pages) can be viewed on-line through the claim inquiry function but it cannot be updated from this screen.

    c. Performing Claim Inquiries
        a. Confirm that the data in the FISS/DDE System matches Cerner.
        b. To start the inquiry process, enter the beneficiary's Medicare number, or leave out the beneficiary's Medicare number and enter any of the following fields:

i. Type of bill (TOB)
ii. S/LOC
iii. Type an "S" in the first position of the S/LOC field to view all the suspended claims
iv. Type a "P" in the first position of the S/LOC field to view all the paid/processed claims
v. Type a "T" in the first position of the S/LOC field to view claims returned for correction
vi. From Date
vii. To Date

c. Once the appropriate claim history displays, type an "S" in the SEL field in front of the claim you wish to view.
   i. Press [ENTER] to display the DDE electronic claim..

d. In the table below you will find Common status and location codes (S/LOC)

Code	Description
P B9996	Payment Floor.
P B9997	Paid/Processed Claim.
P B7501	Post-Pay Review.
P B7505	Post-Pay Review.
R B9997	Claims Processing Rejection.
D B9997	Medical Review Denial.
T B9900	Daily Return to Provider (RTP) Claim – Not yet accessible.
T B9997	RTP Claim – Claim may be accessed and corrected through the Claim and Attachments Corrections Menu (Main Menu Option 03).
S B0100	Beginning of the FISS batch process.
S B6000	Claims awaiting the creation of an Additional Development Request (ADR) letter. [Do not press [F9] on these claims because the FISS will generate another ADR.]
S B6001	Claims awaiting a provider response to an ADR letter.
S B9000	Claims ready to go to a Common Working File (CWF) Host Site.
S B9099	Claims awaiting a response from a CWF Host Site.
S M0nnn	Suspended claims/adjustments requiring Palmetto GBA staff intervention (the "n" denotes a variety of FISS location codes).

STEP 8: ADJUSTING MEDICARE CLAIMS IN THE FISS/DDE SYSTEM

SITUATION 1: CLAIM NEEDS ADJUSTMENT OR CORRECTION

A. You can adjust claims that Medicare has paid or rejected in the DDE system. These claims have been processed by the Medicare adjudication system so rather than resubmitting a corrected claim you have the opportunity to change the claim data and resubmit the claim for Medicare to reprocess through DDE. If you are adjusting a paid claim, Medicare will take the original payment back and issue a new payment. You can adjust claims on-line by performing the following functions:

1. Once signed into the DDE system, select option 3 (from the Main Menu) for claims correction.

2. Confirm that the data in the FISS/DDE System matches Cerner.

3. Regenerate a new claim in Cerner, and then give the new claim to the biller.

Note: This applies in all situations except when adding modifiers to denied lines or when fixing claims posted to the CWF.

4. Once in the Claims and Attachments Correction Menu, select the appropriate option from the Claim Adjustments menu based on the type of bill you wish to adjust; inpatient (117) or outpatient (128). ***(If Void used 118 or 138)***

5. Enter the hospital provider number and a 'P' or 'R' in the S/LOC field. Hit enter without a Medicare HIC number to bring up a listing of paid or rejected claims.

6. Enter the appropriate bill type (TOB field; enter the 1st two numbers) you are looking for under Claims Correction.

Note: Skip step 6 if you add a date of service

7. Once you have the list of claims in front of you select the claim you wish to adjust by placing an 'S' to the left of the HIC # and press enter.

8. After the claim is selected the Claim Update screen will appear. All of the patient's information will be on this screen as well as the date of service (Stmt Dates From), SMS account number (Patient Control Number).

9. Scroll through the claim and change the appropriate information (Claim #). When you identify the charge line you wish to delete place a "D" next to the revenue code for that line. Next, enter the new charge line with the correct information. The new line can be added at the end (after the total line).

10. Type 'OT' in the Adjustment Reason Code field.

Note: You only need to enter a remark when code D9 is used

11. Document the reason for the change in the remarks field.

12. Press F9 to submit the adjusted claim.

13. Document action taken in Cerner and the AR Management Tool.

SITUATION 2: MEDICAL NECESSITY REJECTIONS

A. For Medicare to consider an item or service as "medically necessary," it must meet the following criteria. First, the item or service must be established as safe and effective, consistent with the symptoms or diagnosis of the illness or injury. Second, it must be necessary and consistent with generally accepted professional medical standards and not furnished primarily for the convenience of the patient, attending physician, or other physician or supplier. Third, it must be furnished at the most appropriate level of service that can be provided safely and effectively to the patient.

B. Many services, including certain laboratory, radiology and diagnostic tests, will require the completion of an Advance Beneficiary Notice (ABN) prior to the service being rendered in order for the hospital to receive payment for these services from Medicare. If the hospital does not have an ABN on file, which has been signed by the patient, the hospital cannot bill Medicare or patients for these amounts and will have no choice but to enter a Provider Liable adjustment in the Cerner system. For this reason, emphasis should be placed on obtaining the necessary ABN forms at the appropriate time.

STEP 9: ESCALATE PRIORITY ACCOUNTS PER ESCALATION GUIDELINES (IF NECESSARY)

It is the obligation of the PAFS Collectors to press third party payers for reimbursement on all Past Due and Denied claims. At a minimum the collector should make three (3) distinct collection (reimbursement) attempts with the third party payer before escalating an encounter.

Follow these instructions when escalating encounters:

1. The PAFS Collector shall begin making collection calls 15 days from the Final Bill Date.
    - The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.
    - Based on the outcome of the initial follow-up phone call the PAFS Collector shall set a specific follow-up date using the Action Code Functionality in the patient accounting work driver.
2. If the encounter is still unresolved after two (2) phone calls to the payer the PAFS Collector shall request to speak with a Claim Adjudication Supervisor.
    - The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.
    - Based on the outcome of the second follow-up phone call the PAFS Collector shall set a specific follow-up date using the Action Code Functionality in the patient accounting work driver.
3. If the encounter remains unresolved after three (3) phone calls to the payer and escalation to the Claim Adjudication Supervisor the PAFS Collector shall notify the Assistant Director of Patient Accounting via email that the patient claim is severely past due.
    - The collector shall document this internal escalation request in the Patient Record in the Patient Accounting System.

4. Immediately after notifying the Assistant Director of Patient Accounting that the encounter is past due the PAFS Collector shall notify the patient or the patient's estate, when possible, of their contracted designee's failure to adjudicate their claim.
    - The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.
5. At this time the Assistant Director of Patient Accounting will document the encounter in the escalation log (attached) and will inform the PAFS Collector that the encounter needs to be escalated to the Payer Contract Representative or Account Manager via the payer preferred method of inquiry (e.g., email, phone call, BCBC Past Due Workbook, etc.).
    - The collector shall document this escalation inquiry and record notes in the Patient Record in the Patient Accounting System.
6. If the encounter remains unresolved after two (2) escalation attempts with the Payer Contract Representative or Account Manager the PAFS Collector shall follow-up with the Assistant Director of Patient Accounting.

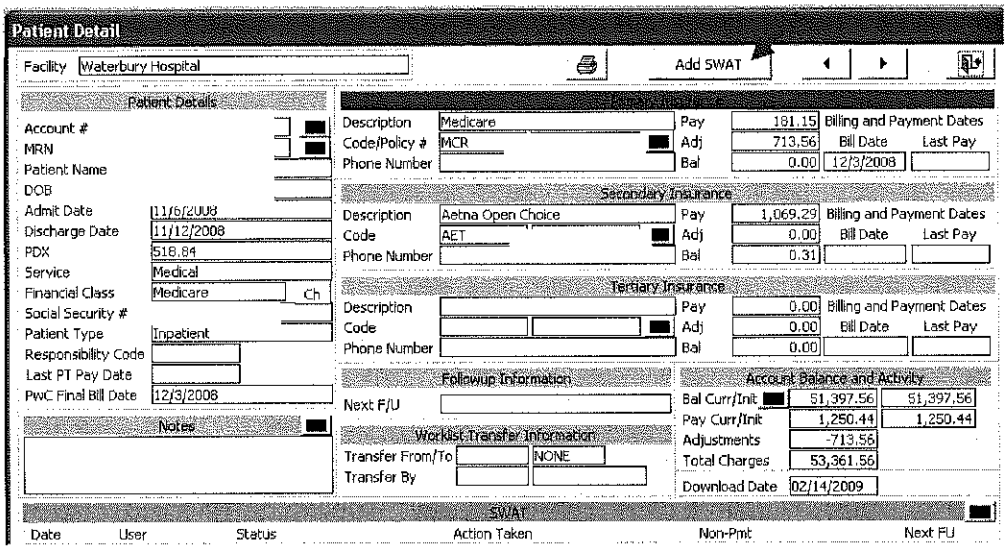
ACCOUNTS REQUIRING ESCALATION TO ASSISTANT DIRECTOR OF PATIENT ACCOUNTING
High Dollar Accounts Unresolved patient accounts with balances greater than $10,000 aged 60 days or greater from the final billed date (90 days or greater for Medicaid and SAGA) must be escalated to the Assistant Director of Patient Accounting after three (3) call attempts.
Unresolved accounts All accounts that require action from another revenue cycle department that have been forwarded to the appropriate department on at least one occasion and have not received a response within three (3) days.

Note: If the hospital is to receive prompt payment from third parties, it is important that the initial billing statement to the third party be prompt, accurate, and clear. Reimbursements can be justifiably delayed if the required forms, medical information, and/or signatures are not provided to the third party payer.

STEP 9: DOCUMENT THE FOLLOW-UP ACTION AND ENTER AN ACTION CODE IN THE A/R MANAGEMENT TOOL AND THE PATIENT ACCOUNTING SYSTEM

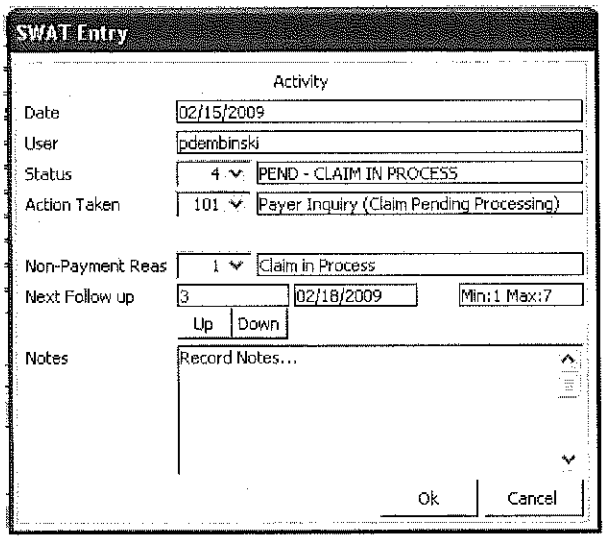
Document all information obtained from the payer inquiry in the Comments Section of the A/R Management Tool and the Patient Accounting System (Cerner).

A. Return the Patient Detail window in the A/R Management Tool
B. Click Add SWAT



Note: The SWAT Button: allows the patient account representative to enter an action code and pend the account for a later follow-up date.

C. The following window appears:



D. You will be required to enter three distinct action codes in the SWAT Entry Screen
   a. Status Code

Status Definitions

0 None
1 PEND - ADJUSTMENT
2 PEND - APPEAL IN PROCESS
3 PEND - AUTH/REFERRAL RESEARCH
4 PEND - CLAIM IN PROCESS
5 PEND - CODING REVIEW
6 PEND - INVOICE REQUEST

7	PEND - MEDICAL RECORDS
8	PEND - PAID/BALANCE IS LATE CHARGE
9	PEND - UPDATING INFORMATION
10	PEND - SPLIT BILL
11	PEND - CORRECTED CLAIM
12	CLOSED - NON-COVERED SRVC/TRANSFERRED TO PATIENT
13	CLOSED - NOT PRIMARY INSURANCE
14	CLOSED - BALANCE TRANSFERRED TO PATIENT
15	CLOSED - WRITTEN OFF

b. Action Taken Code

Action Taken Definitions

ID	Description
1	Supervisor - Transfer Back To User
101	Payer Inquiry (Claim Pending Processing)
102	Billed Another Insurance as Primary
103	Billed other Insurance
104	Called Pt - Left Message
105	Coding/ HIM Issue
106	Corrected Claim
107	Faxed Information to Payer
108	Filed Paper Appeal
109	Medicare Overlap
110	Corrected Claim Online
111	Requested Adjustment
112	Requested Charges to Be Moved
113	Requested Medical Records
114	Requested Payment Transfer
115	Resubmitted Claim with Medical Records/EOB
116	Resubmitted Claim with Appeal Letter
117	Resubmitted Claim
118	Resubmitted Late Charges
119	Sent Letter To Patient Requesting Information
120	Request Supervisor Review
121	Zero Balance

c. Non Payment Reason Code

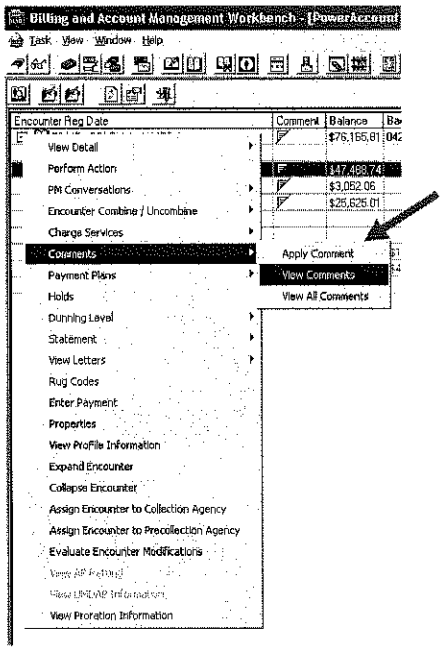
Non Payment Reason Definitions

ID	Description
0	None
1	Claim in Process
2	Claim Not on File
3	COB Issue
4	Duplicate Claim
5	Eligibility / Enrollment / Subscriber

6 Late Charges
7 Maximum Benefits
8 Medical Necessity
9 Needs Adjustment
10 Non-covered Service
11 Overlapping Claim
12 PAID
13 Precert / Authorization
14 Pre-Existing Condition
15 Timely Filing
16 MVA/Liability Case

d. A note is also required in this field
    i. The note can be copied from the A/R Management Tool by clicking the blue button in the SWAT Entry Screen

E. Once all the fields have been properly filled out, then click the "Okay" button. A receipt of the SWAT will appear in the audit trail window at the bottom of the main Patient Detail screen.
F. Return to patient encounter in Profit.
G. Right-click on the encounter scroll to comments, then select Apply Comment.



H. In the new window either paste or re-key the note which documents the results of the payer inquiry.

Again, remember, encounter inquiries are considered productive if they have the following characteristics:

i. Quality data is in the account note
ii. The note is Readable (for examples please refer to the Readability and Appropriateness of Action Examples document) to someone outside of PAFS
iii. The Appropriate Action was taken to resolve or move the Account Forward

Note: The following examples are considered to be acceptable according to the documentation standards noted in the Waterbury Hospital QA Program.

Claim Not Received:

Per (Payer Rep's Name) at (Payer Name & Phone Number), claim was not received. (Re-billed/re-sent) the claim via (Method of Submission, Indicate Fax Number or Address, if applicable) on (Date).

For Checks ONLY:
Confirmed the address on record.

Claim Processing:

Needs Additional Documentation:
Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) still processing. Per Supervisor, (Supervisor's Name), requested additional documentation (Indicate which). Referred account to (Indicate which) department requesting documentation.

No Additional Documentation Needed:
Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) still processing. Requested to speak with a Supervisor. Supervisor, (Supervisor's Name), indicated that claim still processing. Asked Supervisor to expedite processing given the delay.

Claim Processed/Paid:

Sent to Correct Mailing Address:
Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date).

For Checks ONLY:
Confirmed that payment was sent to the correct mailing address.

Sent to Incorrect Mailing Address:
Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date).

For Checks ONLY:
The payer had the incorrect mailing address on file. (Payer Name)'s corrected the address and reprocessed the claim. Also requested that payer stop payment for the original check. Expect payment in (Days).

Claim Processed/Paid/Cashed:

Sent to Correct Mailing Address:
Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received

and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date).

For Checks ONLY:
Confirmed that the payment was sent to the correct address. Requested a copy of the cancelled check to initiate research. Will be faxed to my attention.

Sent to Incorrect Mailing Address:
Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date). The Payer had the incorrect address on file. Therefore, I informed her/him of the correct address and asked for the claim to reprocessed. Also requested that payer stop payment on the original check. Expect payment in (Days).

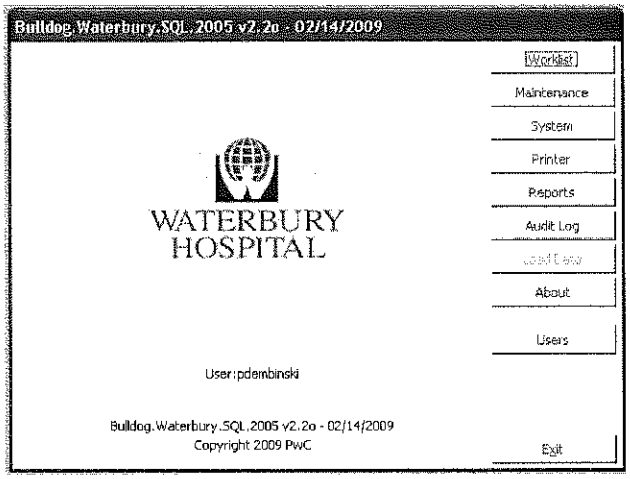
WATERBURY HOSPITAL MEDICAL CENTER

SITUATION AND RESPONSE GUIDELINES
Medicaid Follow-up
All Claims Aged Greater Than
15 Days from Final Billed Date

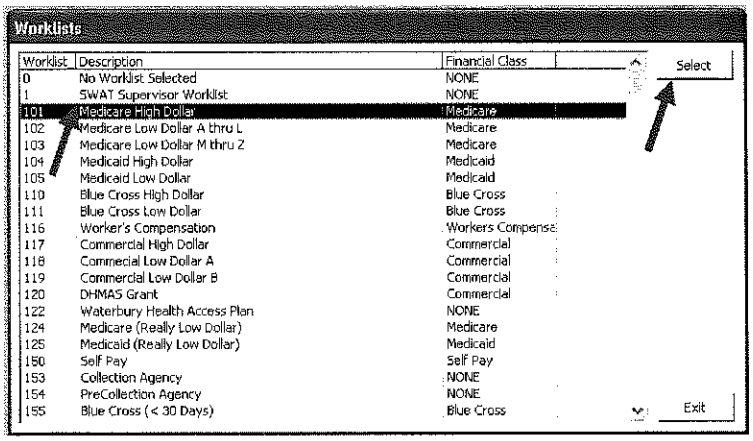
The purpose of this function is to determine claim status and obtain as much information from the payer as possible.

STEP 1: LOG INTO THE WORK LISTS MODULE THEN ACCESS THE WORK QUEUE IN THE A/R MANAGEMENT TOOL (BULLDOG)

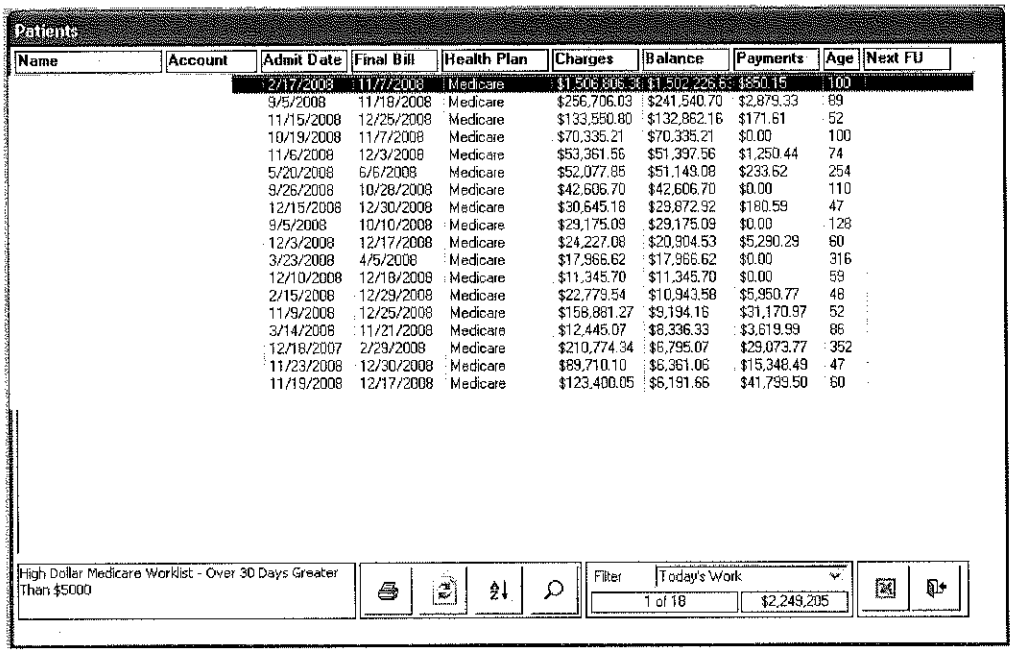
A. Click the **Worklist** button to access your individual worklist(s).



B. If responsible for multiple work lists then select the appropriate Work List.



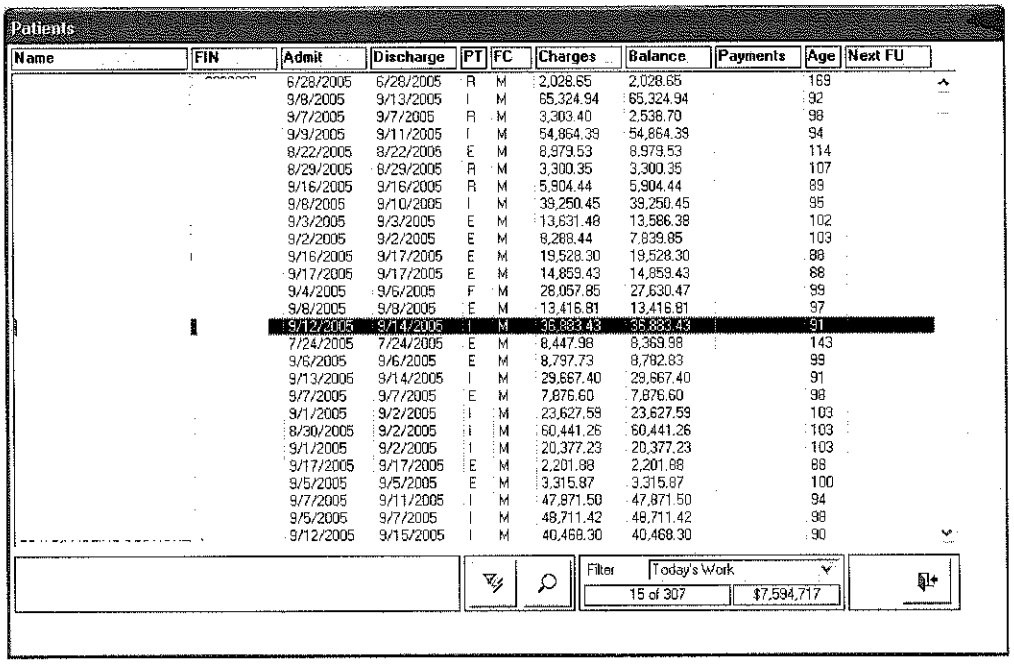
C. The selected work list will now appear in a new window.



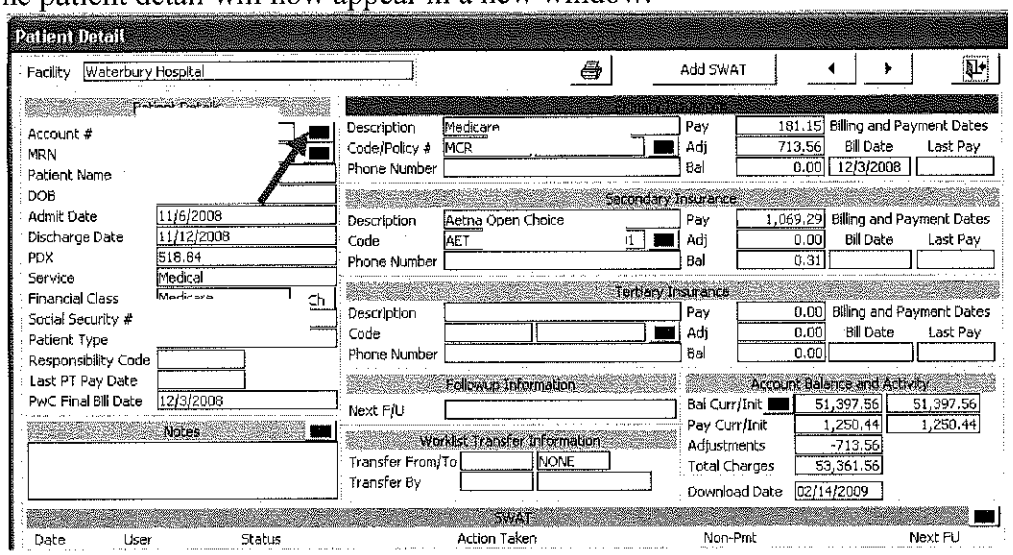
D. Select the encounter with the highest balance.

STEP 2: ACCESS THE PATIENT ENCOUNTER DETAIL WINDOW BY DOUBLE CLICKING THE ENCOUNTER IN THE WORK LIST

A. Double click on the patient encounter in the list to access the patient detail.



B. The patient detail will now appear in a new window.

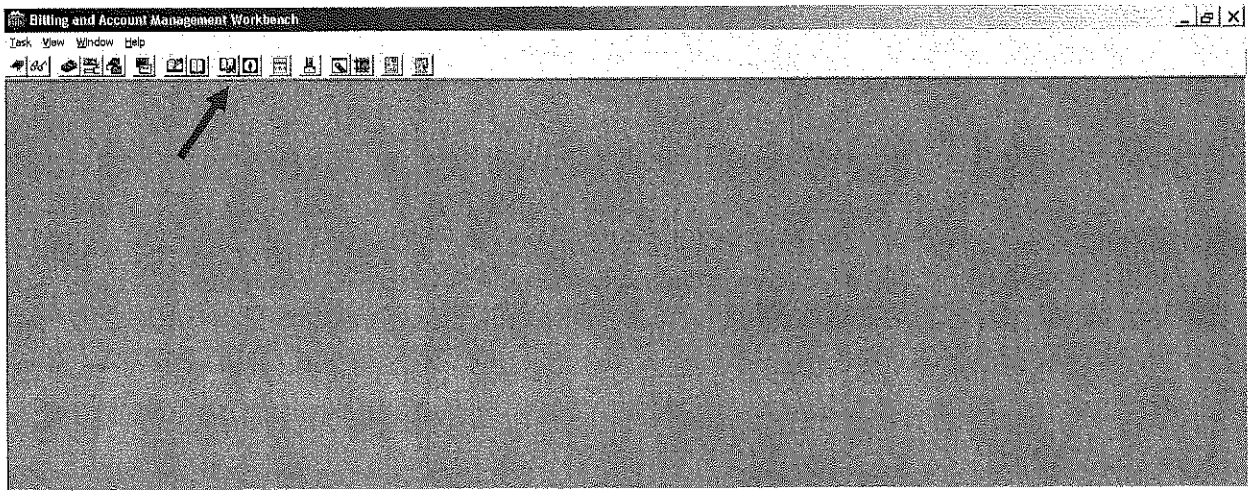


C. Click the blue box next to the Account # to copy the Cerner encounter number.

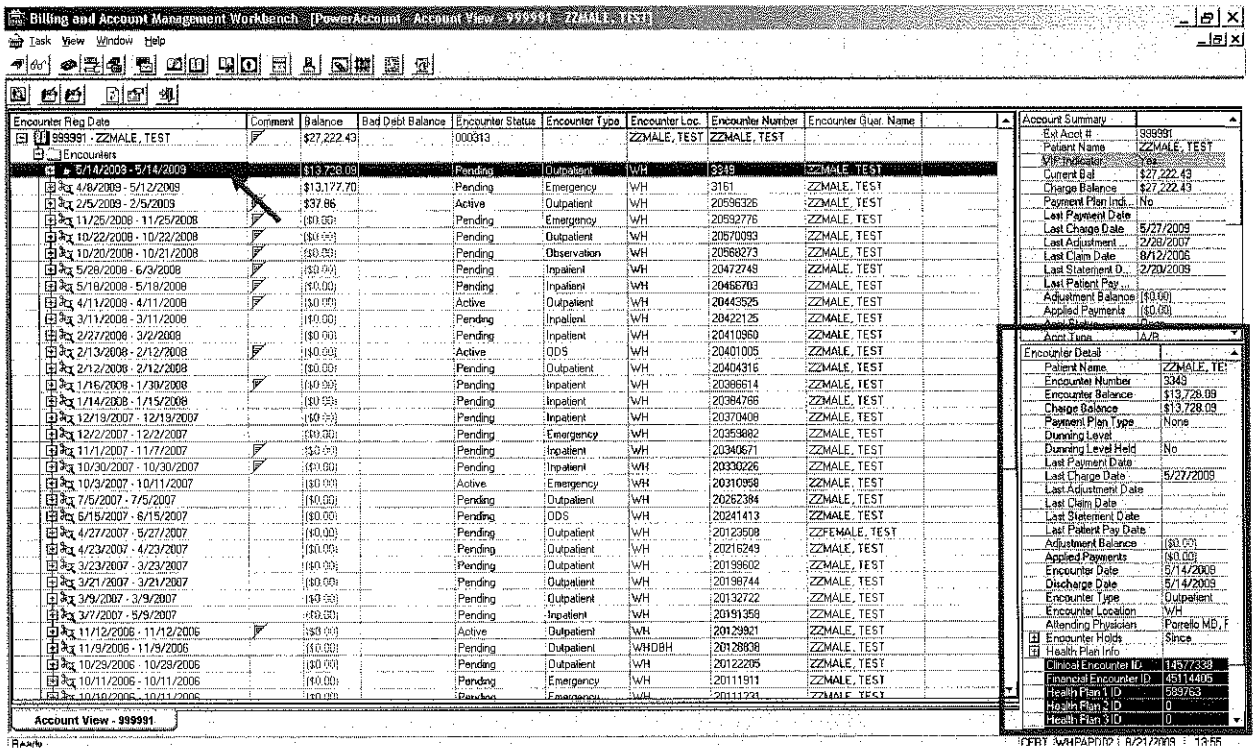
STEP 3: IDENTIFY THE PAYER AND PERTINENT PATIENT DEMOGRAPHIC INFORMATION

Please refer to the patient's insurance information located in the Encounter Detail on the lower right hand side of the Account View screen in the Patient Accounting System (Cerner).

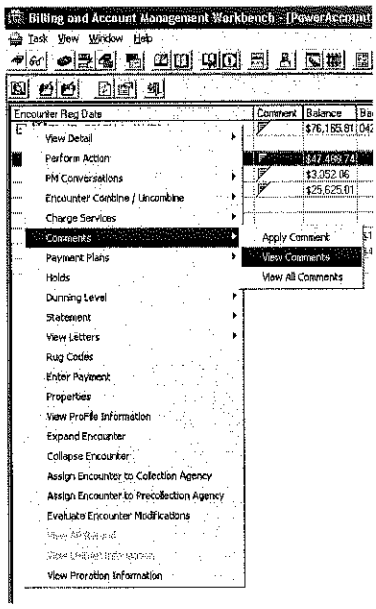
A. Open Profit PABS via the Citrix web application on the computer desktop.
B. From the opening window of Profit click the Patient Account Search icon to retrieve the encounter.



C. Right click then select paste to paste the encounter number into the FIN NBR field on the Account Search window.
D. Press Search to retrieve the encounter.
E. Double click on the patient's name to select the corresponding patient encounter in Profit.
F. The following window appears.



G. Identify the corresponding encounter in the patient record.
H. Review the patient's encounter detail on the lower right hand portion of the window to identify the following information:
    a. Full Patient Name
    b. Most Recent Encounter Balance
    c. Applied Payments(if any)
    d. Applied Adjustments (if any)
    e. Applied Encounter Holds
    f. Health Plan Information, including Payer Phone Number & Address
I. Once the pertinent encounter details have been identified right-click on the encounter, scroll to comments, followed by view all comments to read all prior account notes.
    g. Before contacting the payer make certain that you read all prior notes.



STEP 4: DETERMINE IF THE CLAIM IS DENIED/REJECTED OR IS PAST DUE

Please use this section to guide your decision making process regarding Denied / Rejected or Past Due Claims.

Note: If there is NO Denial or Rejection on the encounter please move to Step 6 - Contact the Payer

If the encounter ***is*** Denied or Rejected refer to the following process:

A. The collector will review each account in his/her work queue and will decide if further follow up action is required. Refer to the process flow (in your binder) should you need assistance regarding the lifecycle of a rejected/denied claim.
   a. Rejected or Denied encounters should either be address within the PAFS Department or routed to other Revenue Cycle Departments for assistance according to the following matrix
   b. PAFS Collectors are instructed to solicit help from other Revenue Cycle departments throughout the hospital when assistance is needed to resolve a Rejected or Denied encounter.

SITUATION 1: No Action Required

If there is no further follow up action required after initial review and there is a self pay balance, the collector will ensure the balance has moved to the self pay benefit order, confirm that all holds have been removed and the adjustment is accurate (if applicable). If there is no self pay balance then the collector will determine the appropriate adjustment code to use either based on the guidelines set forth in the Adjustment Policy.

SITUATION 2: Yes - Action Required

If the claim requires further additional action the collector must first determine who will correct the claim.

SITUATION 2a: Encounter should be routed to another department

a. Rejected or denied encounters requiring action from another hospital department will be referred by the collector to the responsible department via email or voicemail. The request should note the FIN # and the reason why assistance is need and action may be necessary. The collector should then apply the appropriate action code in the AR Management Tool which will record a specific tickle date on the referral. The responsible department must take action within three (3) business days.
   i. If the encounter is routed back to the collector prior to the next follow-up date the collector will perform the action steps according to the department's instructions. (i.e., Adjustment, Submit Corrected Claim, etc.)
   ii. If the claim is ***NOT*** referred back within the specified time frame, then the collector is responsible for escalating the claim to PAFS Management for assistance.

b. Encounters should be routed to other Revenue Cycle Departments according to the following matrix:

Department Responsible for Managing the Rejection	Referred To	Extension
Case Management	Carole Ann Whetmore	7270
Patient Access	Sherri Cianflone	7622
Behavioral Health	MaryAnne Berube	7021
OPMT / EEG / Sleep Center	Deb Terino	7081
Gastroenterology / Intestinal	Barb Lafreniere	6070
Pulmonary / Cardiology	Monica Giacomi	7108
Radiology	Robert Aviles	5859
Laboratory	Anne Lemelin	7604
HIM / Coding	Lawrence Foster	6011

SITUATION 2b: Collector responsible for correcting claim

c. If the collector has the means available to correct the rejection ***without*** the assistance of another hospital department then the collector will take the proper action steps. (i.e., Adjustment, Submit Corrected Claim, etc.)
d. Refer to **Step 5 - Situation specific responses to address rejected or denied encounters** for examples of the appropriate follow-up steps

Note: All scenarios not covered in Situation 2a (above) or the scenarios in Step 5 (below) shall be handled, analyzed and/or corrected by the PAFS Collector. If assistance is needed to resolve the encounter please escalate the situation to the Assistant Director of PAFS.

SITUATION 2c: No action possible

e. If the denial is due to no authorization, non-covered service or no ABN (Advance Beneficiary Notice) where the department states that no other action is possible use one of the approved PLC Transaction Codes to Adjust the claim.

Note: If the collector is unable to determine next steps the claim should be escalated to the Assistant Director PAFS.

Note: In all situations comments regarding the action take are REQUIRED. Please enter specific information succinctly into the AR Management Tool and Cerner as directed according to the Quality Assurance Program Guidelines. (Refer to Step 9 for specific documentation instructions)

STEP 5: Situation specific responses to address rejected or denied encounters

EXAMPLE 1: Collector reviews an encounter with a Coordination of Benefits / Other Insurance rejection type

Response: The collector will contact the insurance carrier to verify the insurance information. If a new insurance policy is obtained update the encounter, then bill the appropriate insurance for payment or rejection. If rejected re-bill with the rejection to Medicaid or SAGA.

EXAMPLE 2: Collector reviews an encounter with a Missing Info rejection type

Response: The collector will contact the insurance company to confirm the type of information that is required. If available please provide the insurance carrier the appropriate information. If you are unable to provide the necessary demographic information you should contact the patient.

EXAMPLE 3: Collector reviews an encounter with an Additional Information Requested rejection type

Response: The collector will contact the insurance company to confirm the type of information that is required. If medical records are required file a request along with the insurance carriers address with the Medical Records Department. The Medical Records Department will send the records to the insurance carrier.

EXAMPLE 5: Collector reviews an encounter with a Missing Authorization Number / Denied Days rejection type

Response: The collector will contact the appropriate department to have them obtain the correct authorization. If necessary, the appropriate department will appeal the claim. The appropriate department shall take action within three (3) business days. If the collector receives no response they should call the department contact.

Note: All scenarios not covered in Situation 2a (above) or the scenarios in Step 5 (above) shall be handled, analyzed and/or corrected by the PAFS Collector. If assistance is needed to resolve the encounter please escalate the situation to the Assistant Director of PAFS.

STEP 6: ACCESSING THE STATE MEDICAID SYSTEM

EDS maintains the provider Web portal which allows for real-time claim submission and adjudication of Medicaid claims

Refer to the Institutional Other Insurance/Medicare Billing Guide (Updated September, 2009) for instructions regarding access to and the submission of Web Claims via the EDS Website.

The guide contains instructions regarding web claim submission to the Connecticut Medical Assistance Program in each of the following situations:

- *Private Insurance as Primary*
- *Billing Instructions - Other Insurance Payment*
- *Billing Instructions - Other Insurance Denial*
- *Billing Instructions – Multiple Other Insurance Policies*
- *Medicare as Primary*
- *Billing Instructions - Medicare Payment*
- *Billing Instructions - Medicare Denial*
- *Billing Instructions - Medicare and Other Insurance*
- *Timely Filing Denials*

The Claim Submission, Resubmission, Adjustment and Inquiry processes are real-time transactions, which the provider can perform on the Secure Web site. Providers may submit claims using Direct Data Entry (DDE), or they may retrieve previously adjudicated claim records to view or use to resubmit claims or adjustments. Claim Submission is used by a provider to enter and submit claim data, and receive claim adjudication results in real-time.

To access Claims Submission, the user goes to the Public Web Portal, navigates to the Provider Page and clicks on the hotlink for secure log-in. The user name and password is entered on the log-in page. If an invalid user name or password is entered, an error message displays and the user is prompted to enter the correct information. When the correct user name and password is entered, the user is taken to the Account Home page.

Note: The following detail can be found in the Web Portal and Automated Voice Response System (AVRS) Provider Manual Chapter 10 (Dated January 1, 2008)

The user selects the Claims Menu, and then the Claim Submission menu item.

The Claim Submission page contains the following hotlinks:

- Institutional
- Professional
- Dental
- Pharmacy
- Search

The user clicks on the hotlink for the claim type that they wish to submit, and is taken to one of the following pages:

- Claim Institutional
- Claim Professional
- Claim Dental
- Claim Pharmacy
- Claim Inquiry

Once on the appropriate claim page, the user completes the sections of the claim by entering data in the appropriate fields. The claim sections are:

- **Billing Information** – containing provider and client identification, prescription and DUR information (Pharmacy).
- **Service Information** – containing Service, Admission and Discharge Dates, Accident indicators, EPSDT indicators, Facility Type Code, and Facility ID.
- **Procedure Code, Condition Code, and Occurrence/Span Code (Institutional only).**
- **Diagnosis Code** – containing Sequence (type of diagnosis) and Diagnosis Code. The Add button allows the entry of multiple diagnosis codes. The Delete button allows removal of individual diagnosis codes.
- **Charges** – containing Total Charges and Other Insurance Denied indicator.
- **Medicare Information** – containing Medicare Paid, Paid Date, Allowed, Deductible and Coinsurance.
- **TPL** – containing Third Party Coverage information, payment and adjustment amounts. An Add button allows the entry of multiple TPL resources. The Delete button allows removal of individual TPL resources.
- **Details** – containing the service detail revenue, procedure or NDC codes, modifiers, tooth number, surface codes, service dates, diagnosis cross reference, rendering provider and taxonomy, units billed, detail charge amount, accident, EPSDT and family planning

indicators. The Add button allows the entry of multiple claim details. The Delete button allows removal of individual claim detail.

• **Hard Copy Attachments** – containing the user assigned control number, attachment type, transmission method and description. The Add button allows the entry of multiple attachment records. The Delete button allows removal of individual attachment records.

STEP 7: CLAIM SUBMISSION, RESUBMISSION, ADJUSTMENTS AND INQUIRY IN THE STATE MEDICAID SYSTEM

Note: The following detail can be found in the Web Portal and Automated Voice Response System (AVRS) Provider Manual Chapter 10 (Dated January 1, 2008)

Sections and their contents vary by the claim type. Billing requirements vary by provider type and are contained in Provider Billing Manuals.

Note: Data requirements that are common to all claims will be supported by field edits to prevent the submission of incomplete claims, or claims containing invalid data elements.

When the user has completed the data entry process, the Submit button is clicked. Missing and invalid data will result in an error message that identifies the problem and allows the user to correct the claim. Once the correction(s) is made, the Submit button is clicked again and the claim data will be sent to the interChange system if it passed all edits.

The claim is adjudicated and the finalized claim data is returned by the interChange system and populates the Claim screen. The adjudicated claim will now contain an Internal Control Number (ICN), Claim Status, Allowed Amount, Paid Amount and EOB codes, if applicable.

If the claim is denied due to a billing error, the user can enter appropriate corrected information in the Claim fields, and click the Submit button to send a new, updated claim. Claims Inquiry is used by a provider to retrieve and view any of their own claims, which match their search parameters, regardless of submission method.

To access Claims Inquiry, the user goes to the Public Web site, navigates to the Provider page and clicks on the hotlink for secure log-in. Alternatively, the user can go to the Claims drop down menu from the Secure Web site and click on the Search hotlink. The user name and password is entered on the log-in page. If an invalid user name or password is entered, an error message displays and the user is prompted to enter the correct information. When the correct user name and password is entered, the user is taken to the Account Home page.

The user selects the Claims Menu, and then the Claim Inquiry menu item. Fields for search criteria are displayed in the Claim Inquiry panel. If the search button is selected without entering any criteria, all claim records for the provider ID are returned.

The search criteria available are the ICN (the unique number assigned to each claim in interChange, Rendering Provider ID, Client ID, Claim Type, Claim Status, From Date of Service (FDOS), Through Date of Service (TDOS) and Date Paid. The user populates one or more fields

with data that matches the claim(s) that they are searching for, and clicks on Search to retrieve the list of matching claims. The Claim Inquiry panel contains a Clear button to clear all field entries.

When there are multiple claim records that match the search parameters, the retrieved claim data is displayed below the Claim Inquiry panel, in the Claim Search Results panel. The Claim Search Results panel displays the ICN, Client ID, FDOS, TDOS, Claim Type, Status, Date Paid, and Amount Billed.

When a claim is selected by clicking on the line in the Search Results panel, one of the following (Claim Dental, Claim Institutional, Claim Professional, or Claim Pharmacy) opens for the selected claim, depending on the claim type selected.

If the claim has been denied due to a billing error, the user can enter appropriate corrected information in the Claim fields, and click the Submit button to send a new, updated claim. The claim can also be resubmitted with no changes if desired. If the claim has been paid and the user needs to file an adjustment, the claim information can be changed as needed by clicking on the Adjust or Void button to send a claim adjustment. If the claim has been edited and the user needs to undo the changes, the cancel button can be clicked.

STEP 8: ESCALATE PRIORITY ACCOUNTS PER ESCALATION GUIDELINES

It is the obligation of the PAFS Collectors to press third party payers for reimbursement on all Past Due and Denied claims. At a minimum the collector should make three (3) distinct collection (reimbursement) attempts with the third party payer before escalating an encounter.

Follow these instructions when escalating encounters:

1. The PAFS Collector shall begin making collection calls 15 days from the Final Bill Date.
    - The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.
    - Based on the outcome of the initial follow-up phone call the PAFS Collector shall set a specific follow-up date using the Action Code Functionality in the patient accounting work driver.
2. If the encounter is still unresolved after two (2) phone calls to the payer the PAFS Collector shall request to speak with a Claim Adjudication Supervisor.
    - The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.
    - Based on the outcome of the second follow-up phone call the PAFS Collector shall set a specific follow-up date using the Action Code Functionality in the patient accounting work driver.
3. If the encounter remains unresolved after three (3) phone calls to the payer and escalation to the Claim Adjudication Supervisor the PAFS Collector shall notify the Assistant Director of Patient Accounting via email that the patient claim is severely past due.

- The collector shall document this internal escalation request in the Patient Record in the Patient Accounting System.

4. Immediately after notifying the Assistant Director of Patient Accounting that the encounter is past due the PAFS Collector shall notify the patient or the patient's estate, when possible, of their contracted designee's failure to adjudicate their claim.
    - The collector shall document this call and record notes from the call in the Patient Record in the Patient Accounting System.
5. At this time the Assistant Director of Patient Accounting will document the encounter in the escalation log (attached) and will inform the PAFS Collector that the encounter needs to be escalated to the Payer Contract Representative or Account Manager via the payer preferred method of inquiry (e.g., email, phone call, BCBC Past Due Workbook, etc.).
    - The collector shall document this escalation inquiry and record notes in the Patient Record in the Patient Accounting System.
6. If the encounter remains unresolved after two (2) escalation attempts with the Payer Contract Representative or Account Manager the PAFS Collector shall follow-up with the Assistant Director of Patient Accounting.

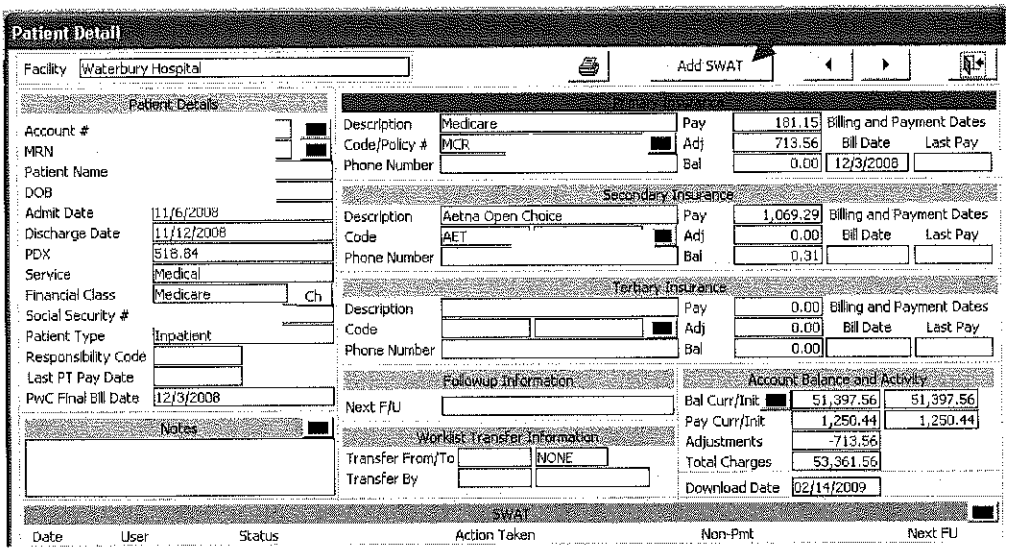
ACCOUNTS REQUIRING ESCALATION TO ASSISTANT DIRECTOR OF PATIENT ACCOUNTING
High Dollar Accounts Unresolved patient accounts with balances greater than $10,000 aged 60 days or greater from the final billed date (90 days or greater for Medicaid and SAGA) must be escalated to the Assistant Director of Patient Accounting after three (3) call attempts.
Unresolved accounts All accounts that require action from another revenue cycle department that have been forwarded to the appropriate department on at least one occasion and have not received a response within three (3) days.

Note: If the hospital is to receive prompt payment from third parties, it is important that the initial billing statement to the third party be prompt, accurate, and clear. Reimbursements can be justifiably delayed if the required forms, medical information, and/or signatures are not provided to the third party payer.

STEP 9: DOCUMENT THE FOLLOW-UP ACTION AND ENTER AN ACTION CODE IN THE A/R MANAGEMENT TOOL AND THE PATIENT ACCOUNTING SYSTEM

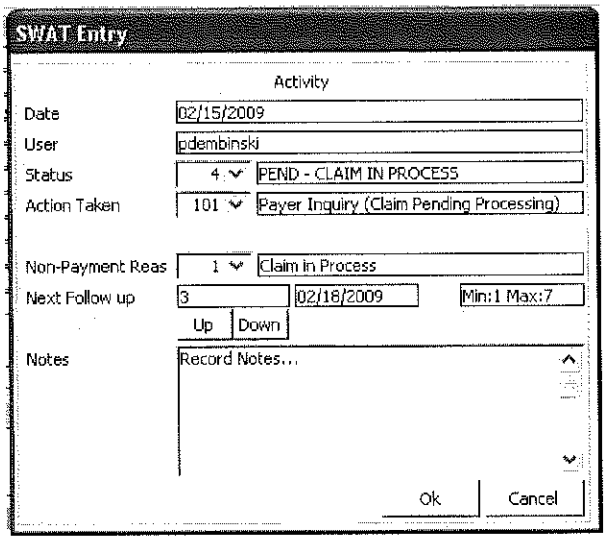
Document all information obtained from the payer inquiry in the Comments Section of the A/R Management Tool and the Patient Accounting System (Cerner).

A. Return the Patient Detail window in the A/R Management Tool
B. Click Add SWAT



Note: The SWAT Button: allows the patient account representative to enter an action code and pend the account for a later follow-up date.

C. The following window appears:



D. You will be required to enter three distinct action codes in the SWAT Entry Screen
   a. Status Code

Status Definitions

0 None
1 PEND - ADJUSTMENT
2 PEND - APPEAL IN PROCESS
3 PEND - AUTH/REFERRAL RESEARCH
4 PEND - CLAIM IN PROCESS
5 PEND - CODING REVIEW
6 PEND - INVOICE REQUEST

7	PEND - MEDICAL RECORDS
8	PEND - PAID/BALANCE IS LATE CHARGE
9	PEND - UPDATING INFORMATION
10	PEND - SPLIT BILL
11	PEND - CORRECTED CLAIM
12	CLOSED - NON-COVERED SRVC/TRANSFERRED TO PATIENT
13	CLOSED - NOT PRIMARY INSURANCE
14	CLOSED - BALANCE TRANSFERRED TO PATIENT
15	CLOSED - WRITTEN OFF

b. Action Taken Code

Action Taken Definitions

ID	Description
1	Supervisor - Transfer Back To User
101	Payer Inquiry (Claim Pending Processing)
102	Billed Another Insurance as Primary
103	Billed other Insurance
104	Called Pt - Left Message
105	Coding/ HIM Issue
106	Corrected Claim
107	Faxed Information to Payer
108	Filed Paper Appeal
109	Medicare Overlap
110	Corrected Claim Online
111	Requested Adjustment
112	Requested Charges to Be Moved
113	Requested Medical Records
114	Requested Payment Transfer
115	Resubmitted Claim with Medical Records/EOB
116	Resubmitted Claim with Appeal Letter
117	Resubmitted Claim
118	Resubmitted Late Charges
119	Sent Letter To Patient Requesting Information
120	Request Supervisor Review
121	Zero Balance

c. Non Payment Reason Code

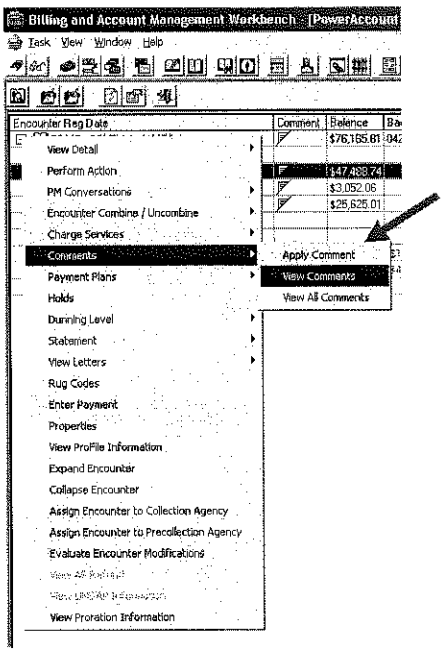
Non Payment Reason Definitions

ID	Description
0	None
1	Claim in Process
2	Claim Not on File
3	COB Issue
4	Duplicate Claim
5	Eligibility / Enrollment / Subscriber

6 Late Charges
7 Maximum Benefits
8 Medical Necessity
9 Needs Adjustment
10 Non-covered Service
11 Overlapping Claim
12 PAID
13 Precert / Authorization
14 Pre-Existing Condition
15 Timely Filing
16 MVA/Liability Case

d. A note is also required in this field
    i. The note can be copied from the A/R Management Tool by clicking the blue button in the SWAT Entry Screen

E. Once all the fields have been properly filled out, then click the "Okay" button. A receipt of the SWAT will appear in the audit trail window at the bottom of the main Patient Detail screen.
F. Return to patient encounter in Profit.
G. Right-click on the encounter scroll to comments, then select Apply Comment.



H. In the new window either paste or re-key the note which documents the results of the payer inquiry.

Again, remember, encounter inquiries are considered productive if they have the following characteristics:

i. Quality data is in the account note
ii. The note is Readable (for examples please refer to the Readability and Appropriateness of Action Examples document) to someone outside of PAFS
iii. The Appropriate Action was taken to resolve or move the Account Forward

Note: The following examples are considered to be acceptable according to the documentation standards noted in the Waterbury Hospital Quality Assurance Program.

Claim Not Received:

Per (Payer Rep's Name) at (Payer Name & Phone Number), claim was not received. (Re-billed/re-sent) the claim via (Method of Submission, Indicate Fax Number or Address, if applicable) on (Date).

For Checks ONLY:
Confirmed the address on record.

Claim Processing:

Needs Additional Documentation:

Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) still processing. Per Supervisor, (Supervisor's Name), requested additional documentation (Indicate which). Referred account to (Indicate which) department requesting documentation.

No Additional Documentation Needed:

Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) still processing. Requested to speak with a Supervisor. Supervisor, (Supervisor's Name), indicated that claim still processing. Asked Supervisor to expedite processing given the delay.

Claim Processed/Paid:

Sent to Correct Mailing Address:

Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date).

For Checks ONLY:
Confirmed that payment was sent to the correct mailing address.

Sent to Incorrect Mailing Address:

Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date).

For Checks ONLY:
The payer had the incorrect mailing address on file. (Payer Name)'s corrected the address and reprocessed the claim. Also requested that payer stop payment for the original check. Expect payment in (Days).

Claim Processed/Paid/Cashed:

Sent to Correct Mailing Address:

Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received

and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date).

For Checks ONLY:
Confirmed that the payment was sent to the correct address. Requested a copy of the cancelled check to initiate research. Will be faxed to my attention.

Sent to Incorrect Mailing Address:
Per (Payer Rep's Name) at (Payer Name & Phone Number), Claim (Claim Number) was received and has been processed/paid with (Batch/Check Number), issued on (Date), in the amount of ($). The (batch/check) was (transmitted/mailed) on (Date). The Payer had the incorrect address on file. Therefore, I informed her/him of the correct address and asked for the claim to reprocessed. Also requested that payer stop payment on the original check. Expect payment in (Days).

WATERBURY HOSPITAL MEDICAL CENTER

SITUATION AND RESPONSE GUIDELINES

PC-Ace and SSI Billing

The purpose of this function is to validate claims and send the bills to the payers in the cleanest form, and receive payment as quickly as possible.

SECTION 1: ACCESS CERNER WHEN CLAIM IS READY TO BE SCRUBBED BY BILLERS

SSI

A. Department Assistant opens up daily emails sent from GlobalScape in Cerner alerting that claims are ready to be scrubbed. The GlobalScape message is generated from the FTP server through a script. Once the files are there, the server will automatically send out the emails. If the files fail, a message is delivered stating the files failed to be generated. (In the event that Department Assistant is out of the office, follow up staff back up and distributes workload to particular billers). Cerner system decides when claims are ready to be scrubbed. Once all bill holds and edit requirements have been met, the system will generate the claims.
    1. This email is sent to Department Assistant, Director, Assistant Director and billing staff at 8 am. An email comes from each of the following sources:
        - SSI
        - 1500s
        - Medicare
        - Medicare Secondary

B. Department Assistant pulls the claim over from Cerner through a link to SSI within the email. These emails are FTP 837 1450 SSI Files. If emails are not received in the morning, Department Assistant calls Help Desk for assistance.

C. Department Assistant goes into the SSI link icon (need user ID and Password
    1. Clicks on the file link (institutional and professional) and clicks "start", which brings claims into SSI
    2. Wait one minute after uploading (the box will not automatically close and 60 seconds is sufficient time for any remaining claims to come through), at which time, the "stop" button is clicked and exit the link.

D. Department Assistant goes into the SSI billing module.
    1. Click on "Translate Cerner", which translates claims into SSI
    2. This could take one hour at the longest. This normally takes between 30-45 minutes to translate. Translation takes up to an hour on the recurring billing days.

E. Once the translation is complete, a series of reports are provided
    1. The **Validation Reports** prints from SSI
        - The Validation Reports shows how many Medicare, State, Commercial and 1500s claims came through
        - These numbers are logged in the tracking notebook and put with the daily billing balance sheets.

- Report Level 1 claims confirmation report is attached to balancing sheet

2. The **Medical Necessity Report** prints out a copy, which goes to the Medicare Part A support staff. Department Assistant keeps original report with the balancing sheet.
3. The **Error Report** that prints is attached to the daily billing balance sheets.
   - Department Assistant looks through the breakdown of claims to make sure all claims have been accepted.
   - If some were rejected, notify Assistant Director, who gives the rejection list to the support staff. Rejections are errors. These errors are either Part A or Part B and they go to the appropriate support staff.
4. The **Medicare Part A Confirmation Report** automatically prints, with all the claims on it. This report is used as confirmation/verification of the accepted and rejected Medicare Claims. If there are no rejected Medicare claims, it is not necessary to keep the report.
5. The **Physician Validation Report** and **Physician Medical Necessity Report** automatically print and are attached to the daily billing balance sheets.
6. The **Medicare Part B (1500s) Report** is printed.
   - Department Assistant notes when the claim does not pass through because the ED doctor did not have a Medicare Provider number (this is the only reason for rejection). Rejection is given to Part B biller.
     - She notes the rejection reason for the claim.

F. All claims are translated and submitted to appropriate billing scrubber

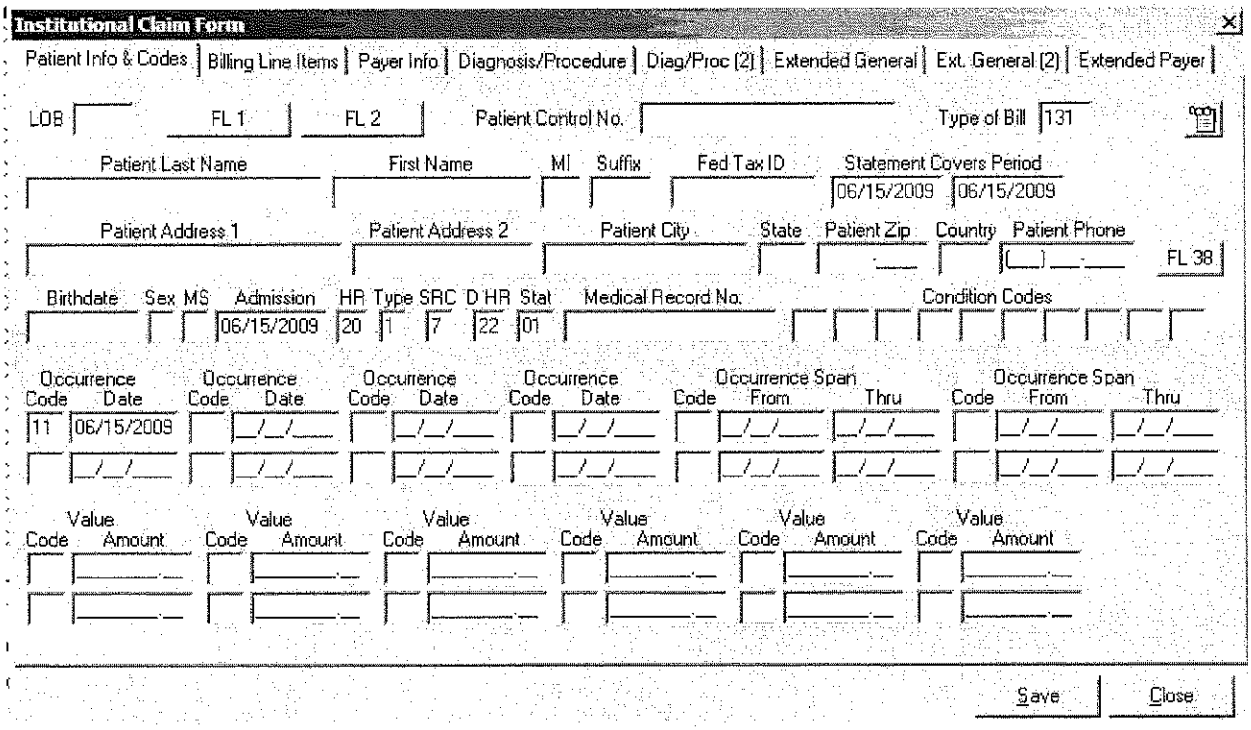
PC-Ace

A. Check email to ensure that claims from previous night are available for download
B. Double-click icon to load claims into PC-Ace. Login names and passwords are necessary for access to PC-Ace. Customized login names and passwords are provided to all billers.
C. Open "Institutional Claim List" and print "Printlink Import Claims" and "Claim Import Detail Report"
D. Review claims for common errors or identifiers, including (but not limited to):
   - Baby names (error to be corrected)
   - ID # should begin with J00
   - ID # should have 9 digits
   - ID # that begins with J000 is part of the Husky program on BCFP
E. Review and adjust all claims with "UNP" (unprocessed) status
   - In the "Patient Info & Codes" tab, change LOB field from MCD to BC
   - In the "Payer Info" tab, select payer ID
F. Close the window and click "Prepare for Transmission" button
   - Chang "Submission Status" to "Production" and click "Prepare Claims"
   - View and print list of prepared claims
   - Upload/submit claims to BC e-Anthem website
G. Miscellaneous
   - If a downloaded claim is deleted from PC-Ace but no action is taken in Cerner, then the claim appears in the billers' work queue

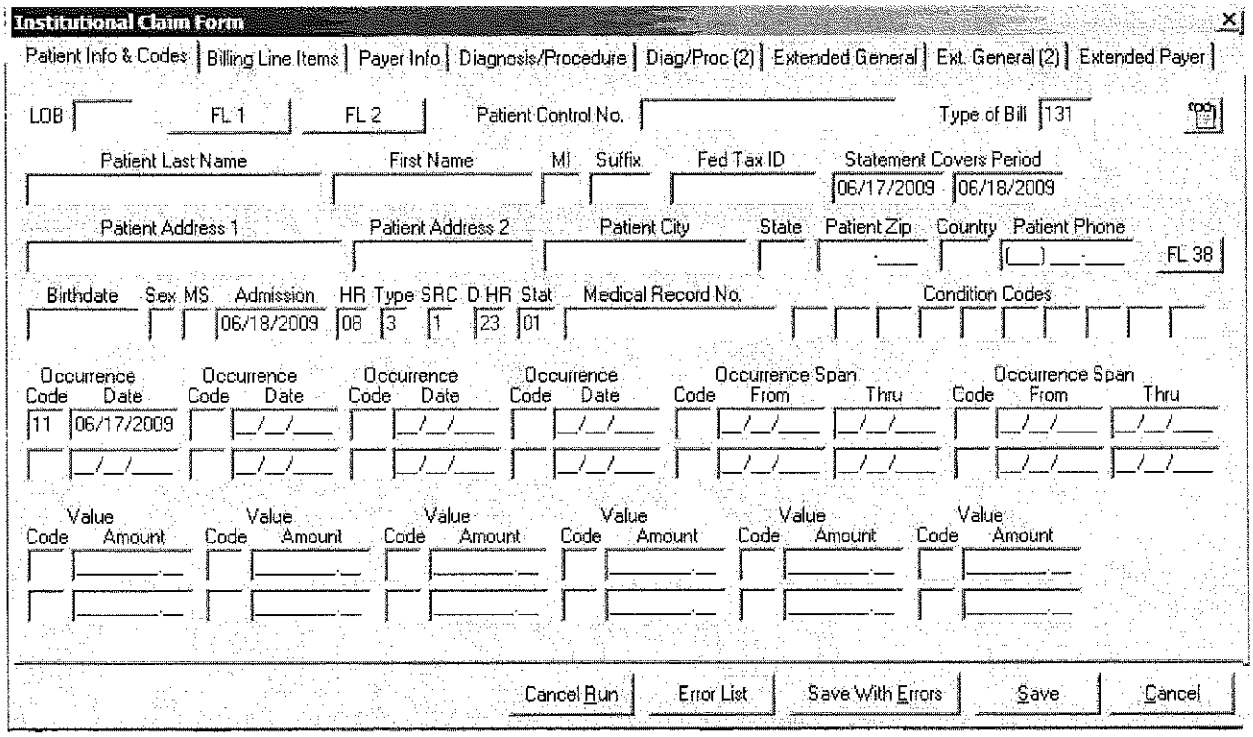
SECTION 2: ACCESS THE BILLING CLAIM

SITUATION 1: BLUE CROSS PC-ACE BILLING

A. Billing team needs to determine if claims are valid to be sent to payers, by addressing the following criteria:
   1. Once the claim is pulled up, billing team needs to determine if the claim is valid. A valid claim is one without errors or necessary revisions and can be sent immediately out to payer. Valid claims are submitted to payers after this initial review. An example of a valid claim (clean claim with no edits) is shown below.

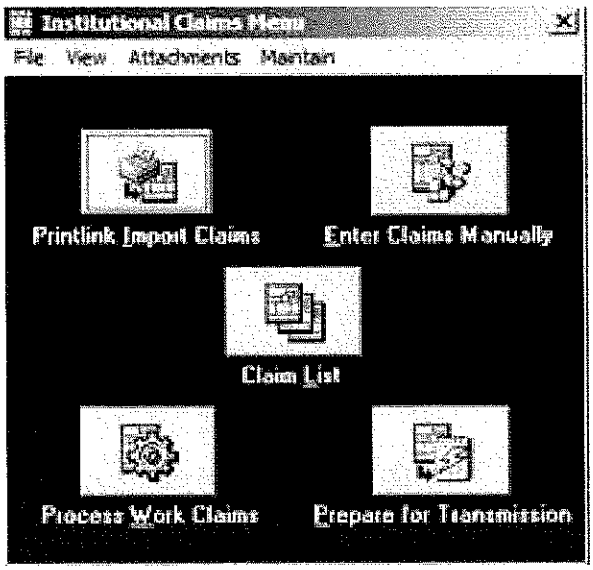


   2. If the claim is determined to be invalid, meaning it requires revisions and editing, the claim is reviewed by the Blue Cross billing staff. The claims are reviewed and worked according to the PC-Ace programmed system edits. Errored claims may be sent via email to departments for further review. A department has 24 hours to respond to the biller. The biller will escalate claims to Assistant Director within 24 hours have passed without a response. An example of an invalid claim (error with admission date) is shown below.



B. The Blue Cross billing team pulls the claims over from PC-Ace, after receiving an email from Waterbury IS indicating the files are ready to be uploaded into scrubbers. Blue Cross billing staff checks email to ensure that claims from the previous night are available for download.

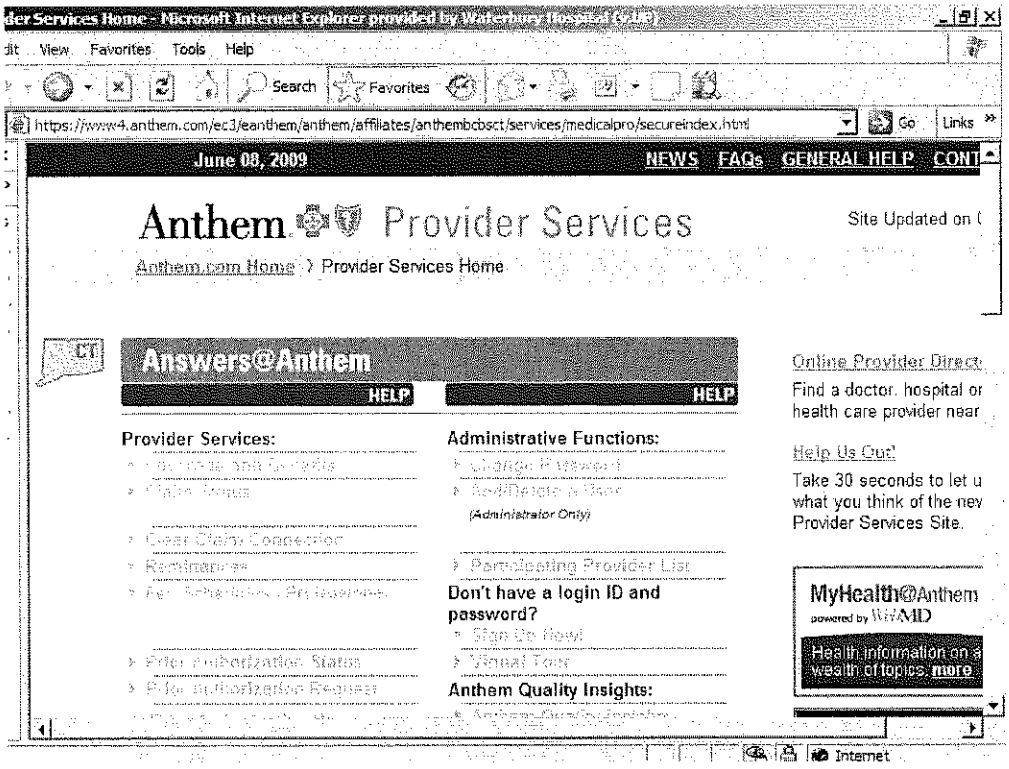
1. Double click on icon to load claims into PC-Ace. Click "Printlink Import Claims" to print list of claims and set aside last page showing the total dollar amount.



2. Click "Process Work Claims" to view list of claims (default is alphabetical order, but should be resorted/filtered by dollar amount)

C. Blue Cross billing team reviews claims with errors and clears rebills. System scrubber instructs billers on what to fix and how to fix errors. Follow system prompts.
   1. Review inpatient claims
      i. Review claims with type of bill 111 to ensure the number of days match and the patient name is complete

D. Send claims to BCBS
   1. Prepare claims for transmission
   2. Print transmission log
   3. Log into BCBS claim website (e-Anthem) and upload/submit claims to e-Anthem.



   4. After 15 minutes, download and print the BCBS response. Attach last page of the Transmission Report to the last page of the Import Detailed Report (from PC-Ace)
   5. Review BCBS response print out, highlight and reconcile failed claims in BCBS website

E. Claims are reconciled at the end of each day to identify un-submitted claims.

SITUATION 1A: BLUE CROSS PC-ACE ERRORS

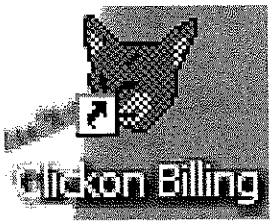
If the Edit is:	And the Issue is:	Then Complete the Following Steps:
Patient ID	Two visit claims listed for the same patient but with two different ID #s	1. Verify the correct ID # in BC system 2. Correct the patient visit in Cerner 3. Delete erroneous claim in Cerner and make note of deletion within the notes section 4. Delete erroneous claims from PC-Ace by right clicking on the claim and selecting "Delete Selected Claim"
NPI	NPI number is required on the claim	1. Look up NPI number (if found in email) through online NPI registry (https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do) a. If resident is used, go to preceptor list and choose the attending physician. Update PM conversation with preceptor and regenerate claim. 2. In Cerner, select ProFit Report Selection 3. Click "Profit Doctor Master - NPI Number" and run report 4. Review for the doctor's name and NPI #; if not present, delete the claim and email Peggy Richardson to request update to doctor's name and NPI in the HNA user. When the email is received back from Registration, regenerate claim.
DOA vs. DOS (Charges with different dates)	Date of Registration (DOA) differs from Charges	1. Delete claim from PC-Ace 2. Print claim from Cerner and enter commet 3. Enter comment in Cerner 4. Highlight charges outside of registration date, FIN#, and ID # at the top.Add a note requesting correction of charges. 5. Put claim in charge bin for correction.
IP Revenue Code	Inpatient Rev codes on an OP TOB 131 or IP claims with no room charges	1. Review documentation to determine IP or OP 2. If no determination, email Karen McBreairty for assistance 3. If IP with no room charges or OP with room charges, and documentation indicates IP, go to PM conversation, get accommodation type and write it on UB with FIN #. Email Assistant Director for time.

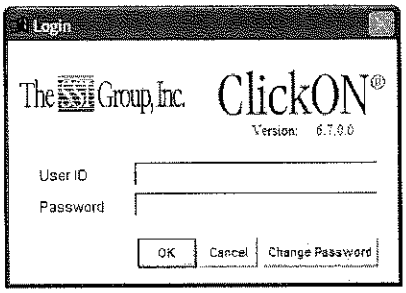
Inpatient visits with errors have higher priority and are given to Assistant Director of Patient Accounts immediately.

SITUATION 2: MEDICARE, MEDICAID, COMMERICIAL SSI BILLING

A. After being notified by the Department Assistant, the Medicare, Medicaid and Commercial billing teams pull the claims over from SSI. Once the claim is pulled up, billing team needs to determine if the claim is valid. The billing teams need to determine if claims are valid to be sent to payer, by addressing the following criteria:
    1. A valid claim is one without errors or necessary revisions and can be sent immediately out to payer. Claims are submitted to payers after this initial review.
    2. If the claim is determined to be invalid, meaning it requires revisions and editing, the claim is reviewed by the billing teams. The claims are reviewed and worked according to the SSI programmed system edits and may be sent to appropriate departments for further review.

B. Log into SSI and load claims
    1. Click on "Billing Module" in SSI and sign in





    2. Click on "claims"
    3. Change access ID to #1 for Medicare, #3 for Medicaid, #4 for Commerical
    4. Select "Claim Status" not equal to billed
    5. Click icon to select claims list
    6. Click Payor column to sort
    7. Correct errors, then click "Validate" to move on to the next claim

SITUATION 2A: MEDICARE EDITS

If the Edit is:	And the Issue is:	Then Complete the Following Steps:
Charge Related	Charges missing or wrong encounter	1. Open claim, print claim, investigate for corrective charge 2. If need removal, highlight charges in question and put in charge bin
Modifier Related	Modifiers need to be added	1. Open claim and determine which modifiers need to be added 2. Verify correct modifiers 3. Make additions to claims 4. Document changes
Retirement Dates need Deletion	Delete retirement dates when generic bypass date is used	1. Open claim and delete retirement dates where needed 2. Verify and document changes
NPI	NPI is missing	1. Look up NPI number (if found in email) through online NPI registry (https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do) a. If resident is used, go to preceptor list and choose the attending physician. Update PM conversation with preceptor and regenerate claim. 2. In Cerner, select ProFit Report Selection 3. Click "Profit Doctor Master - NPI Number" and run report Review for the doctor's name and NPI #; if not present, delete the claim and email Peggy Richardson to request update to doctor's name and NPI in the HNA user. When the email is received back from Registration, regenerate claim.

SITUATION 2B: MEDICAID ERRORS

If the Edit is:	And the Issue is:	Then Complete the Following Steps:
Inpatient or Outpatient Claims	Inpatient error claims checked for spaces, particularly in names	1. Correct names by removing spaces, dashes or other non-alphabetic symbols
POA	POA indicators	2. POA indicators need to be removed
NPI	Missing NPI	1. Look up NPI number (if found in email) through online NPI registry (https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do) a. If resident is used, go to preceptor list and choose the attending physician. Update PM conversation with preceptor and regenerate claim. 2. In Cerner, select ProFit Report Selection 3. Click "Profit Doctor Master - NPI Number" and run report 4. Review for the doctor's name and NPI #; if not present, delete the claim and email Peggy Richardson to request update to doctor's name and NPI in the HNA user. When the email is received back from Registration, regenerate claim.

SITUATION 2C: COMMERCIAL ERRORS

If the Edit is:	And the Issue is:	Then Complete the Following Steps:
MVA	MVA address (but no assigned name) comes over from Cerner	1. Look up MVA name in Cerner 2. Update name in SSI (no comment entered in Cerner)
Discontinued Insurance Carrier	Found claim for insurance carrier that has discontinued	1. Go to Connecticut Department of Social Service website to look up patient's active insurance carrier using client ID, birth date and DOS 2. Update all yellow mandatory fields in SSI and prepare for billing the next day 3. Refer registration errors to Lucy Hughes through Cerner and include comments 4. Delete claim in SSI 5. Once claim is corrected for errors, place corrected copy in Lucy and Barbara's bins for them to pass this information to the registration staff

Claims are reconciled at the end of every day to identify un-submitted claims.

SECTION 3: CORRECTION OF INVALID CLAIMS

A. The claims will remain in the scrubber until the claim edit is resolved/reworked and submitted to the payer. Thus, the biller needs to determine if the claim can be corrected by the billing staff or needs to be sent to the department for correction.

SITUATION 1: CLAIM CAN BE CORRECTED BY BILLER

A. If the claim can be corrected by the biller, the biller will correct the claims and submit/regenerate claims be submitted to the payer the next day.

SITUATION 2: CLAIM CANNOT BE CORRECTED BY BILLER

A. If the claim cannot be corrected by the biller, the claim information is sent by the biller to the departments for edit via email. The next step is to allow the department to correct the claim before sending to payer. The departments must respond to the biller via email within 24 hours. The biller will escalate the claims to the Assistant PAFS Director when 24 hours have passed. The biller will contact the Assistant PAFS Director directly when escalating such issues.
B. If the department can correct the claim within 24 hours, the corrections are made and the billers are notified to correct, submit and regenerate the claims to the appropriate payer.
C. If the department cannot correct the claim within 24 hours, the biller is instructed to allow the claim to go out to the payer to receive denial.

SITUATION 3: RETURN TO PROVIDER (RTP) IN THE SUSPENSE FILE

A. The DDE system allows the provider to correct claims that have rejected.
    1. In order to view the rejection message, press the F1 key. **Note:** If the claim has more than one rejection code, place the cursor under the first number of the subsequent rejection code(s) when F1 is pressed to obtain their explanation.
    2. After first error has been corrected, other errors may be found on this account requiring correction. Fix as many of these errors yourself. Assistance from other members of the revenue cycle team may be needed to fix other errors. For example, seek the assistance of the Health Information Management Department if it appears that a modifier code is missing or if a diagnosis code is needed. When this occurs, forward documentation to the HIM representative. Sometimes, information does not crossover from the billing system through the electronic interface then on to the DDE system. If review of the billing system determines that a missing HCPCS Code did not crossover, then enter it into the DDE screen. Inform manager when it is discovered that fields that do not crossover. Management can work with the appropriate department to see if the interface can be improved to capture this information for future claims.

3. After completion of all necessary corrections, hit the "F9" command. If one or more corrections remain, which cannot be fixed at this time, hit the "F3" command. Both of these commands will return you to the suspended claims listing and you can work other accounts.
4. Document action taken in Cerner and the AR Management Tool.

All aforementioned activity is documented in the account notes by the biller. Appropriate documentation includes the claim status, claim number, follow-up dates, claim payment and payer responses. Blank or missing documentation does not suffice in the account notes.

SECTION 4: DATABASE - BILLING EDITS TRACKING

A. Billing edits will be input into the Clean Claims Database on a daily basis. Database is located in the ProFit folder on Citrix. While there is no ultimate "owner" of the database, user list includes Sue Constantino, Roseann Slywka, Rosetta Ferrucci, Anita Chadha, IS and PwC team.
B. Edit information is input, as required, including date, edit number, frequency and edit description
C. Daily billing edit data is input based on the data within the shared drive.
    1. SSI billing edit data is found within the S: drive under the ProFit folder, within the Cerner folder.
        i. Within the ProFit folder, edits are separated by hospital and physician.
    2. Both sets of edits (hospital and physician) are input into the Billing Edits module in the Clean Claim Database
    3. Edits are also found in the daily billing tracking sheets printed each morning.
        i. These sheets include complete detailed descriptions of each edit, as well as frequency.
D. The billing edits tracking module is found within the Clean Claim Database, by selecting the "SSI Billing Edit Detail" button on the main form.
    1. The subsequent data fields are populated with the date (mm/dd/yyyy), count of edits and edit numbers.
        i. Edit descriptions automatically populated if the edit number has already appeared in the system before.
        ii. If a new edit number is input into the module, a prompt will appear, asking edit detail. This edit detail is saved and added to the complete edit descriptions data.
E. Process continues until all daily edits are input into the database.
F. The Billing Edits report, run from this daily input of data is brought to the weekly billing edits workgroup meeting
    1. Top edits are addressed, as well as follow up discussions

Waterbury Hospital
CREDIT & COLLECTION MANUAL

REIMBURSEMENT OF SELF PAY BALANCES

CATEGORY: Credit & Collection	**POLICY: REIMBURSEMENT OF SELF PAY BALANCES**
REVIEWED:06/10	**REVISED: Jul/03, Mar/04, Jan/07, Dec/07,Dec/09,Jun/10**
RETIRED:	**Comment:**

PURPOSE: To ensure that reasonable collection efforts are established for self-pay deductibles, co pays, co-insurances and other outstanding patient due balances.

POLICY: To collect self-pay balances in a timely manner, at any point during the revenue stream up to and including referral to collection agencies.

PROCEDURE:

GENERAL GUIDELINES:
The following guidelines will apply for patients with no insurance or for self pay balances after insurance has paid:

- Private pay elective admissions will require 50% payment prior to service and remainder paid within 30 days after service, in order to obtain discounted rates.
- Cosmetic surgeries will be expected to pay 100% of the discounted fee, prior to service.
- Third-party - patients will be requested to pay estimated deductibles, co-pays and co-insurance amounts based on verification of coverage prior to admission, while patient is in-house, at time of discharge or post-discharge.
    - Scheduled patients will be informed of their responsibility prior to service.
- Patients with no insurance are responsible for the full balance due.
- Medicaid - patients with state or city welfare are **not** required to make cash payments prior to admission.

POST DISCHARGE:
At time of discharge [to include expirations] or conclusion of outpatient services, Encounters are placed in suspense for a specified number of days to allow charges to be posted and other functions such as coding, to occur. In-patient Encounters, for example, are held for a minimum of 3 days, outpatients for 6 days.

Once the minimum days have been exhausted, a final bill will be created dependent on the resolution of all billing edits.

FINAL BILL:
A final bill is created and submitted either electronically or by hardcopy to all primary third-party carriers and to patients if there is no insurance listed.

- Self pay patients receive an itemized statement at time of final bill.
- Any patient can request an itemized statement at any time.

When the insurance payment is received, the Encounter is reviewed and the appropriate contractual allowances are processed as applicable. The liability for the remaining balance becomes the responsibility of secondary or tertiary carriers or the patient for deductibles, coinsurances or co-pays.

OUTSOURCING AGENCY – Extended Business Office:
Self-pay balances from day one and self-pay balances after insurance are referred to an outsourcing agency.

- Encounters are reviewed and patients are dunned as per the NCO self pay workflow.
- If a self-pay day one patient provides insurance information, the Encounter is reclassified and billed to the insurance carrier. The Encounter will remain with NCO for third-party follow up.
- Self-pay patients receive a series of 3 statements at approximately 30-day intervals.
- Patients who are on repayment contracts will receive monthly statements until the balance is resolved.
- Insurance and self-pay follow-up, including outbound IVR, phone calls, etc. is also performed.
- On-site outsourcing liaisons complete daily work lists of Encounters requiring review and action. The liaisons work in both the hospital and outsourcing HIS systems.
- Self-Pay Discount Policy is available for full payment within the first 30 days.

Unpaid balances are returned to Waterbury Hospital after all dunning is completed, for referral to outside collection agencies, and are considered bad debts.

PATIENT STATEMENTS:
For Encounters which are not outsourced or that are returned from the outsourcing agency and which require statements:
Encounters are placed in a Manual Statement dunning level

- Self-pay patients receive 4 statements at 30-day intervals.

REPAYMENT CONTRACTS:
The Patient Encounters staff and the outsourcing agency will always attempt to collect the full amount due on every self-pay Encounter. If however, the patient is unable to pay the full amount, a repayment contract can be initiated according to established guidelines.

Patients who do not adhere to their payment plans will eventually be referred for outside collection and are considered bad debts.

INDIGENT OR MEDICALLY INDIGENT PATIENTS:
At any point in the revenue stream, patients may inquire or request to be considered for eligibility for free bed funding or discount programs. [See the following associated policies:

- Uninsured Patient Policy
- Patient Assistance Policy
- Charity Care Policy

Waterbury Hospital
CREDIT & COLLECTION MANUAL

SCHEDULED PRIVATE PAY PATIENTS' PAYMENT OBLIGATION

CATEGORY: Credit & Collection	**POLICY: Scheduled Private Pay Patients' Payment Obligations**
REVIEWED:06/10	**REVISED: Jul/03, Mar/04, Jan/07, Dec/07,Dec/09,Jun/10**
RETIRED:	**Comment:** Replaces the following policies: Elective Private Pay Patients; Pre-Paid Cosmetic Procedures; Pre-Service Collection to Include Cosmetic Procedures

PURPOSE: To provide a mechanism for scheduled self pay patients to pay at a discounted rate providing all payment obligations are met prior to service.

POLICY: It is the policy of Waterbury Hospital to set expectations for self pay scheduled services to insure prompt payment, and to provide scheduled self pay patients with payment options.

PROCEDURE FOR ELECTIVE SERVICES EXCLUDING COSMETICS:
Elective self pay procedures will be discounted @ 40% off estimated total charges at time of scheduling providing the patient does the following:

- **At time of scheduling, if patient is self pay [no insurance], patient will be required to pay 50% of the estimated discounted amount prior to service.**
- **Central Scheduling will send the patient a notification letter [exhibit 1]**
- **Remainder will be due within 30 days after service is rendered**.

If the patient is not able to comply with these arrangements, they will be required to meet with the R&B Liaison and/or the WHAP coordinator to review qualification for Medicaid, Saga or other government/state programs.

If the patient chooses not to follow this process, the scheduled procedure will be canceled. Surgical Services will be notified accordingly.

COSMETIC PROCEDURES

Patients having elective cosmetic procedures will be required to pay 100% of the discounted amount prior to service.

Process:

Operating Room

- The OR will determine the fee based on the procedure.
- Cost estimate is given to physicians via Payment Notification Form [see exhibit 2]

Physician Office

- Physician office will review the form with the patient, complete the form and fax to the OR and Central Scheduling [for PAT scheduling].
- Physician Office will book the case with the OR and send the letter to the Cashier office.

Central Registration

- The patient will be pre-admitted with estimated date of arrival for preadmission testing.

Cashier Office

- The cashier will keep the letter on file
- Payment will be sent to the cashier [from the patient] or patient will make payment on arrival to hospital.
- Once patient has the service and the final bill is produced, the cashier will write off the difference between the charges and the payment, providing there are no extenuating circumstances.

Extenuating Circumstances:

- If the surgery is cancelled and the patient had pre-admission testing, the patient will be responsible to pay for these tests.
- If extended recovery is used, there will be an additional charge.
- If the patient is admitted as an inpatient or observation, there will be additional charges. Payment for these charges will be collected on discharge or payment arrangements will be set up.
- If the procedure/treatment exceeds the estimated time given, the patient will be responsible for the difference.

A script was developed to provide guidance to the ERM staff in their efforts to collect cash. The following script will be used to assist the staff.

"I understand you are a self-pay for this service and you received a payment notification form from your doctor for an estimation of cost. "

- *Have you made that payment yet?*
- *If yes, call will be ended*
- *If the patient states check to be mailed, call is ended*
- *If no payment to date has been made the registrar will remind the patient/caller that payment is expected 72-hours prior to service*
- *If the patient is ready to pay by credit card (Visa, MasterCard, Amex, Discover) the registrar will give the patient the encounter number and transfer the patient/caller to: Customer Service at Extension 7116 for payment*

If the patient is unable to make payments or requires Financial Assistance a Customer Service representative will assist the patient with payment plans or programs offered by the hospital.

Exhibit 1

To:

_____

_____

_____

_____

Date: _____

Re: PRIVATE PAY SCHEDULED SERVICE

Dear Patient:

You are scheduled for a procedure as a private pay patient. To take advantage of discounted rates, the following payment obligations must be met:

- **50% When procedure is scheduled**
- **Remainder within 30 days of service**

Thank you for allowing us to provide your care. Please contact me for any questions/concerns by phone or email. **Please send the initial 50% payment the following address:**

Waterbury Hospital Central Scheduling
64 Robbins Street
Waterbury, CT 06721

A stamped self-addressed envelope is included for your convenience.

Thank you,

_____ **Phone** _____
Email _____

Central Scheduling Department
Waterbury Hospital Patient Access / Financial Services

Exhibit 2

WATERBURY HOSPITAL
64 ROBBINS STREET
WATERBURY, CT 06708
Phone (203) 573-6177
Fax (203) 573-6734

COSMETIC SURGERY PAYMENT NOTIFICATION FORM

NAME: _____ DATE: _____

PROCEDURE: _____

ESTIMATED COST: _____

APPROXIMATE DATE OF SURGERY: _____

All cosmetic surgery patients are required to make **full payment** 72 hours prior to the surgery. **Payment can be sent to: Waterbury Hospital, 64 Robbins Street, Waterbury, CT 06708 ATTN: Patient Access Financial Services.** Please write the name of the patient in the memo section of your check. If you wish to pay by Cash, Mastercard, Visa, Discover or American Express, you can come in to our Customer Service unit located on the ground floor, adjacent to the Information Desk.

Based upon the information provided by your doctor, you were given a good faith estimation, which represents the typical cost associated with the estimated time for the procedure/treatment. If the procedure/treatment exceeds the estimated time given, you will be responsible for the difference. The actual cost may vary and is dependent upon the extent and nature of the procedure performed. If pre-admission testing is performed and the surgery is cancelled, you will be responsible for the cost of the pre-admission test charges. You are responsible for charges incurred by Consulting Pathologists, Diagnostic Radiology and Waterbury Anesthesiology Associates.

Patient's Signature: _____

Date: _____

Patient's Telephone number: _____

Waterbury Hospital
CREDIT & COLLECTION MANUAL

SELF PAY DISCOUNTING

CATEGORY: Credit & Collection	POLICY: SELF PAY DISCOUNTING
REVIEWED:06/10	REVISED: 08/03, 01/07, 02/08, 11/09,06/10
RETIRED:	Comment:

PURPOSE: To offer options to self pay patients who may have difficulty resolving open balances.

POLICY: It is the policy of Waterbury Hospital Health Center to provide opportunities for the self-pay patient to receive a discount based on prompt payment and/or income/family size.

PROCEDURE:
Patient Assistance is always an option for the patient who states they cannot resolve their outstanding balance/s. An application is required in all cases. The patient will be required to attest to the validity of information and documentation by signing the Financial Application form

Patients will be screened to see if there they will qualify for any assistance programs.

DISCOUNT OPTIONS:

PROMPT PAY DISCOUNT
For patients with **NO** insurance, a prompt pay discount of 25% will be applied for full payment of the **full** outstanding balance within 30 days of receipt of first statement. **This discount requires no financial application.**

The following message will be reflected on the first statement effective March 1, 2008 –

Please inform us if you have insurance coverage. If you have NO insurance coverage and the balance is paid IN FULL within 30 days, you may qualify for a discount. Please call 1-800-600-0407 for details: Monday – Friday, 8am – 4:30pm. Thank You.

Patients who call the number on the statement will be speaking with our outsourcing agency which will inform them of the 25% discount and give them the adjusted balance. If the patient agrees to pay, a hold will be placed and monitored by NCO. When the patient has paid, the encounter will be put into a special disposition code which will alert our on-site liaison to put thru the allowance.

For patients who are unable to pay the balance in full within 30 days, NCO will set up a formal payment plan using Waterbury Hospital repayment guidelines. If the patient is unable to meet this repayment obligation, the financial application process will be followed for qualification for sliding scale or other programs.

The following balances are **not applicable to discounting** due to contractual obligations between Waterbury Hospital and the payer:

- Copays, coinsurances and deductibles

Patients requesting assistance with these balances will be required to fill out a financial application for charity care or submission to PAC [if balance is >$1000]

BALANCE CRITERIA
Individual Encounter Balance - <$200 - no discount applies

Aggregate balance – $201 to $999 - patient must complete a financial application to qualify for sliding scale discount [self pay only] or charity care. Presentation to PAC not required.

Aggregate balance - >$1000 – patient must complete a financial application for sliding scale discount [self pay only] or presentation to PAC. Case can be presented to PAC a second time if the patient is unable to comply with payment arrangements on balance after discount.

SAMPLE SCENARIOS for PATIENTS WITH COPAYS, COINSURANCE or DEDUCTIBLE BALANCES

Medicare patient is unable to pay their inpatient deductible of $1068.
Patient must complete a financial application for presentation to PAC. No discount is applied.

Patient has co pay of $50 for ED visit.
No discount applies. Balance is due.

Patient has 5 encounters with co pay balances of $100 each, totaling $500.
Patient must complete a financial application. Case does not need to be presented to PAC. Balance is written off to charity care if patient qualifies.

FPIG SLIDING SCALE MATRIX GUIDELINES

The sliding scale matrix will be utilized for patients who cannot resolve their balance within 30 days. Waterbury Hospital utilizes the Federal Poverty Income Guidelines [FPIG] for development of the sliding scale matrix. [The FPIG is updated annually usually in March]

INCOME/FAMILY SIZE <200% of FPIG
If income and family size place patient between zero and 200% of the FPIG, the patient will qualify for 100% discount. The patient should be directed to apply for city/state or other assistance programs before applying the discount.

INCOME/FAMILY SIZE >200% of FPIG, LEVEL 1 - 5
For qualifying patients, sliding scale will apply and patient may qualify for a minimum discount of 25% up to a maximum discount of 65%

INCOME/FAMILY SIZE IS BEYOND LEVEL 5
Patient will not qualify for a discount. Payment is expected.

SAMPLE LETTER

Date:_____

Dear Patient:

APPROVAL:
Based on the information that you provided,

_____% discount has been granted on your self pay balance/s.

DENIAL:
☐ You are over income and do not qualify for a discount at this time

☐ Your balance is due to a copay, coinsurance or deductible.

Prompt payment of your balance due is appreciated.

Please feel free to contact me if you have any questions.

Very truly yours,

Waterbury Hospital Health Center
Patient Financial Services

Waterbury Hospital
CREDIT & COLLECTION MANUAL

RE-PAYMENT GUIDELINES

CATEGORY: Credit & Collection	**POLICY: RE-PAYMENT GUIDELINES**
REVIEWED: 06/10	**REVISED: 06/10**
RETIRED:	**Comment:**

PURPOSE: To provide guidelines for the setting up of formal and informal payment plans.

Policy: It is the policy of Waterbury Hospital to resolve open balances via repayment plans within a reasonable time period.

Procedure:
Informal Payment Plans
Informal plans are assigned automatically by the Cerner system when a patient makes a payment that is less than the total balance due and a formal payment plan has not been established.

Informal plans follow the Self Pay statement cycle flow.

Unpaid balances will flow to our outsourcing agency for further collection efforts and on to collection agencies if not paid, following routine guidelines.

Formal Payment Plans
Patients can request formal payment arrangements for open balances. Customer Service representatives work with patients to determine the acceptable guidelines.

Formal payment plans are set up within the Cerner system for a specific amount to be paid on a monthly basis, starting on a specific date.

The statement flow reacts to payment and non-payment according to the Formal Payment Plan cycle. [See Statement Handbook]

Customer Service staff follow up on formal payment plans.

Re-Payment Guidelines

Balance	Re-Payment Period	Formula
$ 0 – 25.00	In Full within 30 days	In Full
$26.00 - $100.00	In Full within 60 days	Balance / 2
$101.00 - $300.00	In Full within 6 months	Balance / 6
$301.00 - $1000	In Full within 12 months	Balance / 12
$1000 - $5000	In Full within 24 months	Balance / 24
$5000 - $10,000	In Full within 30 months	Balance / 30
> $10,000	In Full within 36 months	Balance / 36

Any re-payment plans are not to extend beyond 36 months.

Patients who are unable to make payments in accordance with the above guidelines must fill out a financial application form.

- If the patient complies and qualifies for sliding scale discount, discount will be applied.
- If the patient complies and does not qualify for sliding scale discount, they must adhere to the repayment guidelines above.
- If the patient does not comply, they will be notified that we cannot enter into a formal plan.

Patients cannot dictate to Waterbury Hospital, what is an acceptable payment. To set up a payment plan that would beyond extend 36 months is to effectively provide the patient with an interest-free loan. This is not acceptable.

Customer Service will make every effort to work with a patient to determine an affordable plan within the guidelines above. A combination of payment options can be established, for example, a lump sum payment with repayment on remaining balance.

Further collection efforts will be warranted for those encounters which remain unpaid or are not set up in acceptable re-payment plans.

Waterbury Hospital
CREDIT & COLLECTION

CO PAY COLLECTIONS INITIATIVES

CATEGORY: Credit & Collection	POLICY: Co-pay Collections Initiatives
REVIEWED:07/10	REVISED: 07/10
RETIRED:	Comment:

PURPOSE: To increase cash collections by informing patients of their obligations prior to service and at point of service.

POLICY: In an effort to maximize cash collections, payments will be requested prior to service by the ERM staff with a follow-effort by the PAFS Customer Service staff. At time of scheduling if a co-payment is identified a payment will be requested.

Process: A script was developed to provide guidance to the ERM staff in their efforts to collect cash. The following script will be used to assist the staff.

> **Thank you for choosing Waterbury Hospital for your Healthcare needs, it has been determined by your insurance company _name__ that you have a co-payment of $250.00, for this admission. How will you be paying for this today? We accept: Visa, MasterCard , Discover and American Express.**

MATERNITY:

- Pre-admit form needs to be referred to Verifier by Front end Registration staff
- Verifier will verify primary insurance and obtain co-payment amount for this admission. If 2ndry or tertiary insurance apply no pre-service collections required
- All comments will be noted on the front of the admit form in red ink.
- Admit form goes back to front end registration for pre-admit registration to occur
- Registrar will be required to contact the patient advising of co-payment due for admission 72-hours prior to admission.
- Registrar will be responsible to collect co-payment over the phone: Scripting: Thank you for choosing Waterbury Hospital for your Healthcare needs, it has been determined by your insurance company **_name__** that you have a co-payment of $250.00, for this admission. How will you be paying for this today? We accept: Visa, MasterCard and American Express.
- If partial payment is made the follow-up on the balance will need to be done by Patient Accounting/Customer Service

AM ADMISSIONS WHICH INCLUDES: C-SECTION DELIVERIES:

- Pre-registration team working on fax machine will need to refer reservation fax to pale green file folder labeled: C-Section AM's to do: Verifier Garner will pull daily.
- Verifier will verify primary insurance and obtain co-payment amount for this admission. If 2ndry or tertiary insurance apply no pre-service collections required
- All comments will be noted on the front of the reservation form in red ink
- Reservation form goes back to pre-registration area in the yellow file folder labeled-completed AM's-sections and the fax person will delegate as alpha assigned for pre-registration to occur
- If Verifier identifies during verification the insurance is incorrect or terminated the reservation form goes back to pre-registrar who will obtain the correct information
- Reservation form goes back to Verifier for verification and co-payment determination (repeat of process bullet #3 and #4 above)
- Registrar will be responsible to collect co-payment over the phone: Scripting: Thank you for choosing Waterbury Hospital for your Healthcare needs, it has been determined by your insurance company **_name__** that you have a co-payment of $250.00, for this admission. How will you be paying for this today? We accept: Visa, MasterCard and American Express.
- If partial payment is made the follow-up on the balance will need to be done by Patient Accounting/Customer Service
- STAT orders put on Verifier's desk
- Add-on orders put on Verifier's desk

If the patient is unable to make payments or requires Financial Assistance a Customer Service representative will assist the patient with payment plans or programs offered by the hospital.

EMERGENCY ROOM

The Emergency Department staff collect co pays at the bedside or at the Discharge Office.

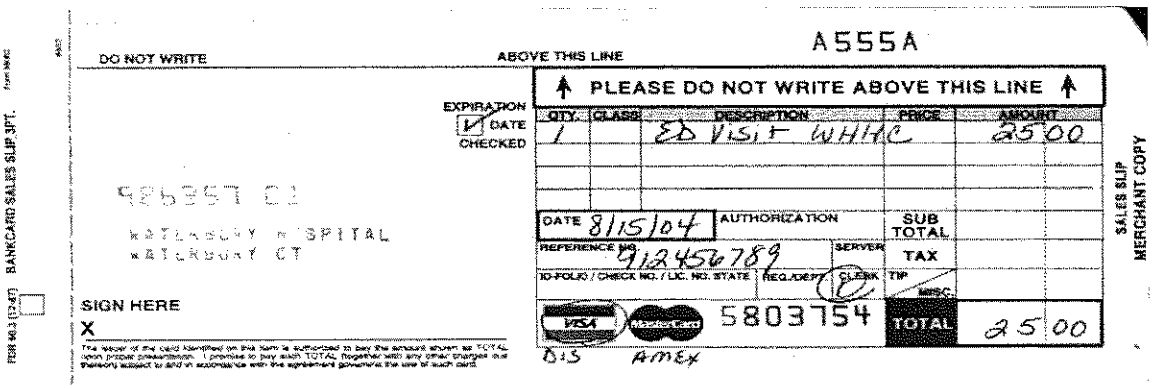
ED co-payments can be paid using cash, credit cards or checks. Co-payments will be collected from 9:30am to 5:00 pm Monday through Friday. Collection will not take place on Nights, Weekends or Holidays.

Morning Procedure

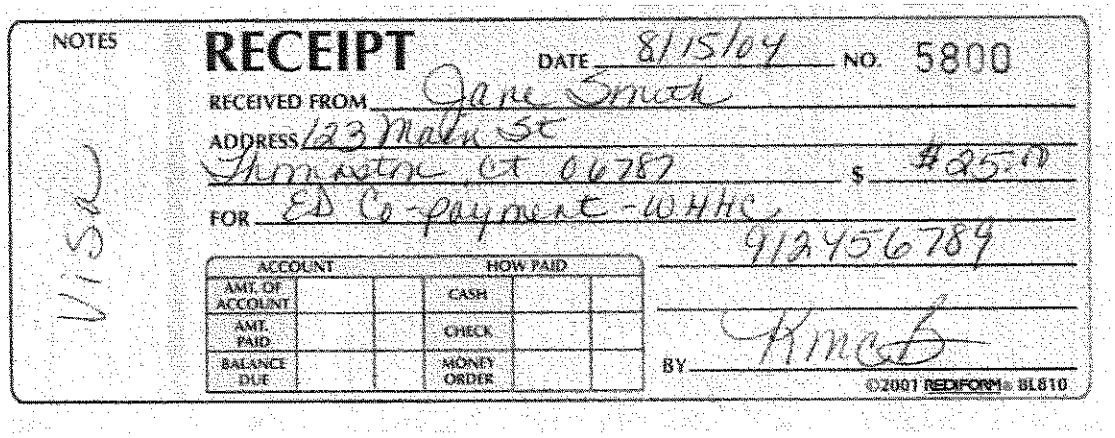
- Blue cash bag will be picked up from Cashier's office each day between 9:00 and 9:30am. Since the bag will contain the $50.00 start money, a security escort may be obtained to the ED from the cashier's office.
- Place the $50.00 start money in the cash drawer in the ED Discharge Office.
- **The register drawer MUST remain locked at ALL times.**

Credit Cards

- WHHC accepts American Express, Discover, Visa and Master Card
- Swipe credit card using sales slip.
  - Check expiration date
  - Write "ED Visit" in the description field.
  - Enter amount of co-payment in the "Amount" field.
  - Enter Date
  - Enter account number in "Reference No." field.
  - Place your initials in the "Clerk" field.
  - Circle credit card type. (MC, Visa, etc.)
  - Have patient sign if possible.



- Complete receipt from receipt book entering:
  - Date
  - Patient's name
  - Patient's address
  - Amount of payment
  - For: ED Co-payment, WHHC
  - Place account number in the section under "For".
  - Enter credit card type in the "Notes" section. (MC, VISA, etc.)
  - Sign


NOTES

RECEIPT DATE 8/15/04 NO. 5800

RECEIVED FROM Jane Smith

ADDRESS 123 Main St

Thomaston, CT 06787 $ $25.00

FOR ED Co-payment - UHHC

912456789

ACCOUNT			HOW PAID		
AMT. OF ACCOUNT			CASH		
AMT. PAID			CHECK		
BALANCE DUE			MONEY ORDER		

BY KMcD

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- DO NOT give patient the credit card sales slip receipt or hand written receipt. Please explain to them, the hospital cashier will mail all receipts to them after processing.

- Staple both receipts together and place in cash drawer.

- Be sure to verify patient address and update in system if needed.

Checks

- Checks should be made out to Waterbury Hospital.
- Complete receipt from receipt book entering same information as with Credit Cards except credit care type in the Notes section.
- Enter check number in the "check field".
- Give patient receipt.
- Place check in cash drawer.

Cash

- Fifty dollars will be kept in the cash drawer for change.
- Complete receipt entering all information described in the Credit Card section.
- Enter the amount of cash received in the "Cash" field.
- Provide patient with receipt.

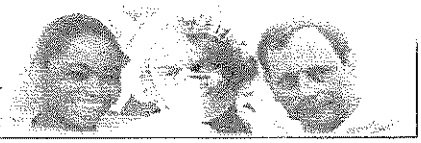
Balancing

- Make a tape of all cash transaction and total, all Credit Card transactions and total, and all Check and total. Leave $50.00 in the cash drawer as follows:
  - 10 ones
  - 6 fives
  - 1 ten

  (If the exact denominations are not available, change can be made the next morning in the cashier's office.)

- Cash should be counted and added by domination.
- Add total of credit card, cash, and check payments together.
- Make 2 copies of receipt book for your transaction and highlight payment amount.
- Add amount of receipts together.
- Total of cash, credit card and check payments should equal the total amount of receipts.
- Staple adding machine tape to one copy of the receipt book signing your name.
- Have another registrar check your addition, producing another tape.
- Attach the second tape to one copy of the receipt book having the second person sign their name to both receipts.
- Place all payments and one copy of receipts with tape attached in the blue cash bag. Label the $50.00 start money and also place in bag and lock.
- Bring blue Case bag to the Operator's office off the front lobby. The Cashier will pick up in the morning.

WATERBURY HOSPITAL
HEALTH CENTER
caring makes a world of difference



INFORMATION SHEET for SELF PAY PATIENTS

SCHEDULED SERVICES – Patient Access – 203-573-

Program / Policy	Patient Information
Scheduled Services [excluding cosmetic]	• Elective self pay procedures will be discounted at 40% off estimated charges at time of scheduling, providing patient pays 50% of the estimated discounted amount prior to service. • Remainder is due within 30 days after service is rendered. • If the patient is unable to comply with these arrangements, they will be required to meet with a representative to discuss qualification for Medicaid, Medicaid L.I.A. or other government/state programs. • The scheduled service will be postponed or canceled if patient chooses not to participate in the process.
Cosmetic Procedures	• Patients having cosmetic procedures will be required to pay 100% of the discounted amount prior to service.

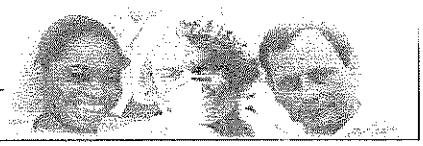
NON-SCHEDULED SERVICES – Customer Service – 203-573-7116 [see below]

Program / Policy	Patient Information
Prompt Pay Discount	• For patients with NO insurance, a discount of 25% will be applied after full payment of the outstanding balance is received within 30 days of first statement. • For patients WITH insurance, the following balances are <u>not eligible</u> for discounting: o Co-pays, coinsurances & deductibles. • Patients requiring assistance with these balances will be required to complete a financial application.
Sliding Scale	• The sliding scale will be utilized for patients who are unable to resolve their balances within 30 days. Waterbury Hospital utilizes the Federal Poverty Income Guidelines to determine eligibility. • Completion of a financial application is required.
Payment Plans	• For balances that are determined to be paid over time, payment plans can be set up according to established guidelines.

PATIENT ASSISTANCE for OUTSTANDING DEBTS – Customer Service – 203-573-7116

Patients who are unable to pay an outstanding bill can request assistance by contacting Patient Financial Services.
Once a request has been made, Customer Service staff work with the patient/representative to determine the qualification for Waterbury Hospital's various programs. <u>A financial application is required</u>. As appropriate, cases are prepared and presented to the Patient Assistance Committee for review. Free bed funds are applied for full/partial approval. Note: In cases of partial approval, patient may be asked to pay a nominal amount to reflect acknowledgement of responsibility towards outstanding debt.

Customer Service representatives are available Monday thru Friday, 8:00am – 4:30pm. Telephone hours are Monday thru Friday, 8:30am – 3:30pm. Walk-ins are welcome. 203-573-7116



Waterbury Hospital
CREDIT & COLLECTION MANUAL

BANKRUPTCY

CATEGORY: Credit & Collection	**POLICY: Bankruptcy**
PAGE:	**ORIGINATED: 12/5/97**
REVIEWED:06/10	**REVISED: 01/07, 12/07, 07/08,06/10**
RETIRED:	**Comment:**

SCOPE: Identify and process Bankruptcies.
PURPOSE: To insure that Encounters are appropriately flagged when bankruptcy is filed, and the appropriate forms are received and filed.

POLICY: To abide by the provisions of the Bankruptcy Law and cease all collection activity on Encounters when bankruptcy has been formally filed.
PROCEDURE:
The following guidelines apply when handling Encounters for patients who have filed bankruptcy:

NOTICE OF BANKRUPTCY

Upon receipt of bankruptcy notice, all encounters on or before the filing date are flagged with the Bankruptcy Indicator and all collection efforts are suspended. A copy is sent to our collection agencies.

The Encounters are documented that a bankruptcy notice was received, and there should be no patient contact at this time.

If a Proof of Claim is requested, the Cashier will forward any outstanding debts to the Bankruptcy court.

All Bankruptcy notices are filed and maintained by the Cashier.

DISCHARGE OF DEBT

Upon receipt of a discharge of debt notice, all open encounters with a date of service prior to the Bankruptcy discharge date, will be written off using the appropriate alias transaction code.

The Discharge of Debt is matched with the Bankruptcy Notice for record-keeping purposes and filed together.

Any Encounters that are granted a discharge of debt, and have been referred to a collection agency, are returned from collection to process the Bankruptcy adjustment.

BANKRUPTCY REPORT

The Bankruptcy Report should be checked at least quarterly to follow-up on cases where a discharge of bankruptcy has not yet been received.