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.

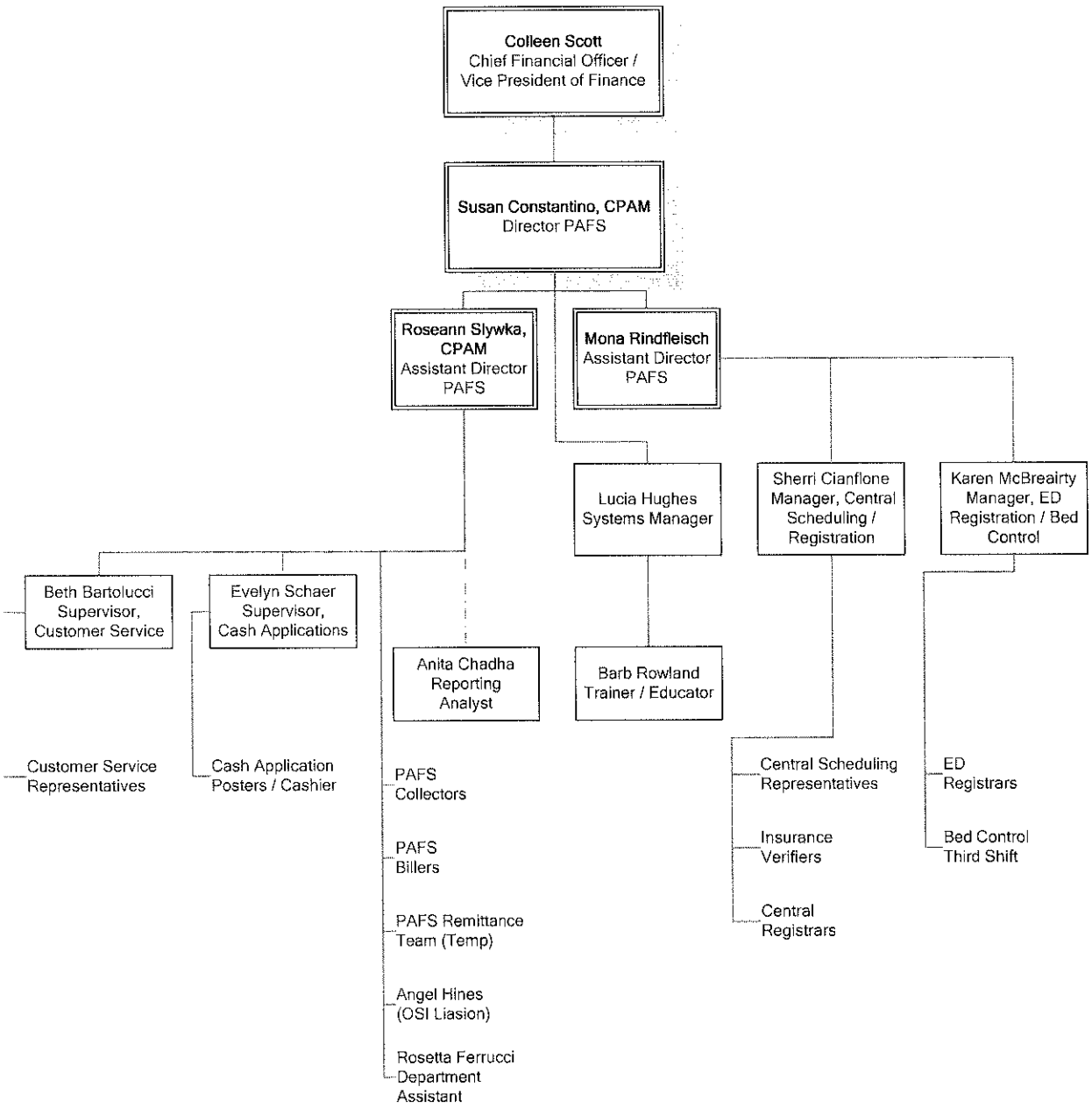
HOURS OF OPERATION:

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:

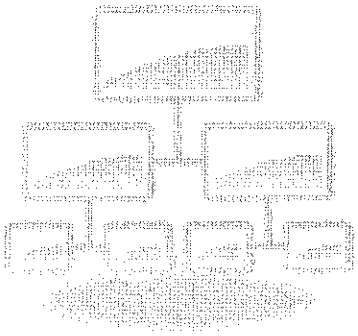
The information in the Patient Accounting Financial Services Department Scope of Service section has been designed to indicate the general nature and level of work performed by employees within the department. It is not designed to contain or be interpreted as a comprehensive inventory of all duties,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

TABLE OF CONTENTS

SELF PAY

- 01_Reimbursement of Self Pay
- 02_Scheduled Self Pay Patient Payment Obligations
- 03_Self Pay Discount Policy
- 04_Self Pay Re Payment Guidelines
- 05_Co pay Collection Initiatives

FINANCIAL ASSISTANCE POLICIES

- 01_Bankruptcy
- 02_Charity Care
- 03_DMHAS IP Grant
- 04_Financial Assistance Application
  - 04a_Glossary of Definitions
- 05_Financial Assistance Checklist
- 06_Free Care Patient Information
- 07_Free Care Policies Matrix
- 08_Patient Assistance Committee Bylaws
- 09_Patient Assistance Policy
- 10_Uncompensated care Pool Regulations
- 11_Uninsured Patient

STATEMENTS

- 01_Patient Statement Policy
- 02_Profit Statement Cycle Information

PRICE QUOTING

- 01_Price Quoting Policy

BAD DEBTS

- 01_Bad Debt Collection Agency Referral
  - 01a_Fair Debt Collection Practices Act
- 02_Medicare Bad Debt Referrals
  - 02a_Addendum CMS Regulations - Medicare Bad Debt
- 03_Medicare Bad Debt Reporting

PATIENT ACCOUNTING QUALITY ASSURANCE

- 01_QA Billing Program
- 02_QA Billing Review Indicators
- 03_QA Billing Industry Standards
- 04_QA Follow Up Program
- 05_QA Follow Up Review Indicators
- 06_QA Follow Up Industry Standards

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:

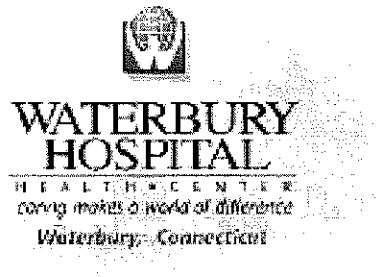
1. Each Credit Balance encounter shall be reviewed and analyzed to determine the cause of the negative balance:
    a. PAFS Staff are required review the patient account in Cerner, review the EOB (or 835 File), consult the payer contract and/or fee schedule (if available), and confirm the posted payment 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

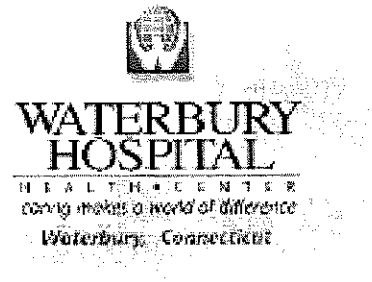
Sup/Dir Signature:_____

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.

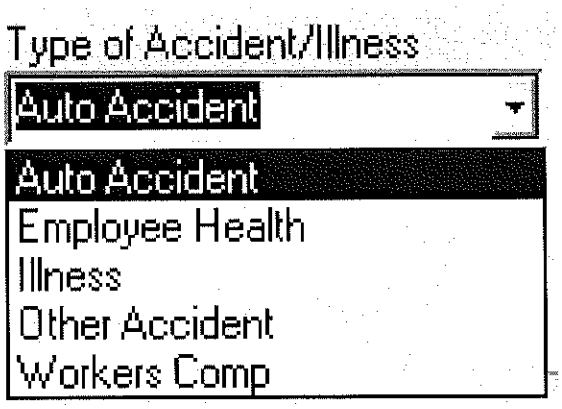
DATA QUALITY

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

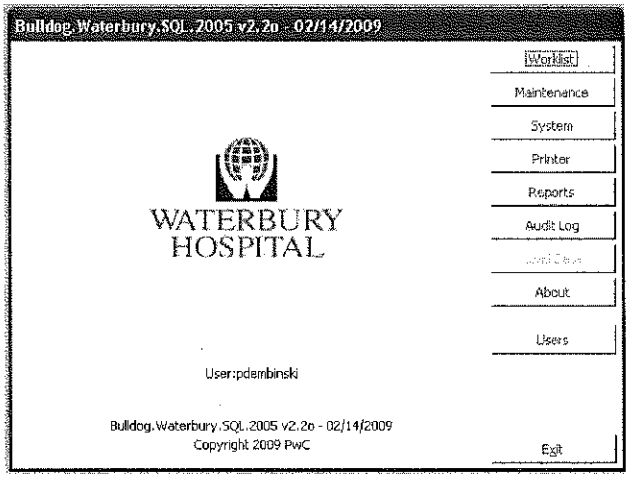
SITUATION AND RESPONSE GUIDELINES

Commercial Follow-up
All Claims Aged Greater Than
15 Days from Final Billed Date

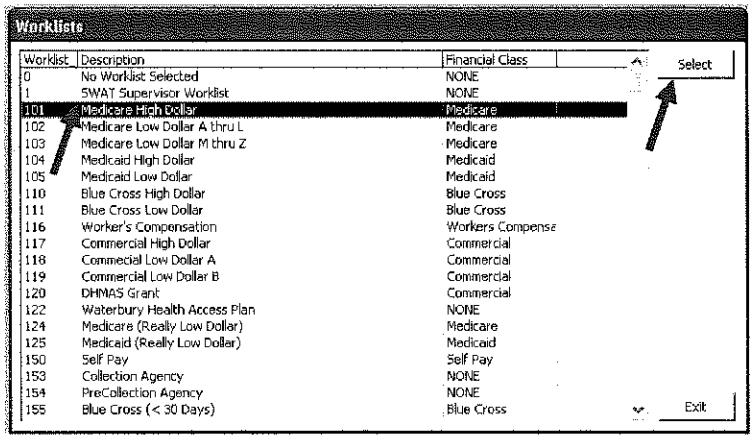
The purpose of this function is to determine claim status and obtain as much information from the payer as possible.

STEP 1: LOG INTO THE WORK LISTS MODULE THEN ACCESS THE WORK QUEUE IN THE A/R MANAGEMENT TOOL (BULLDOG)

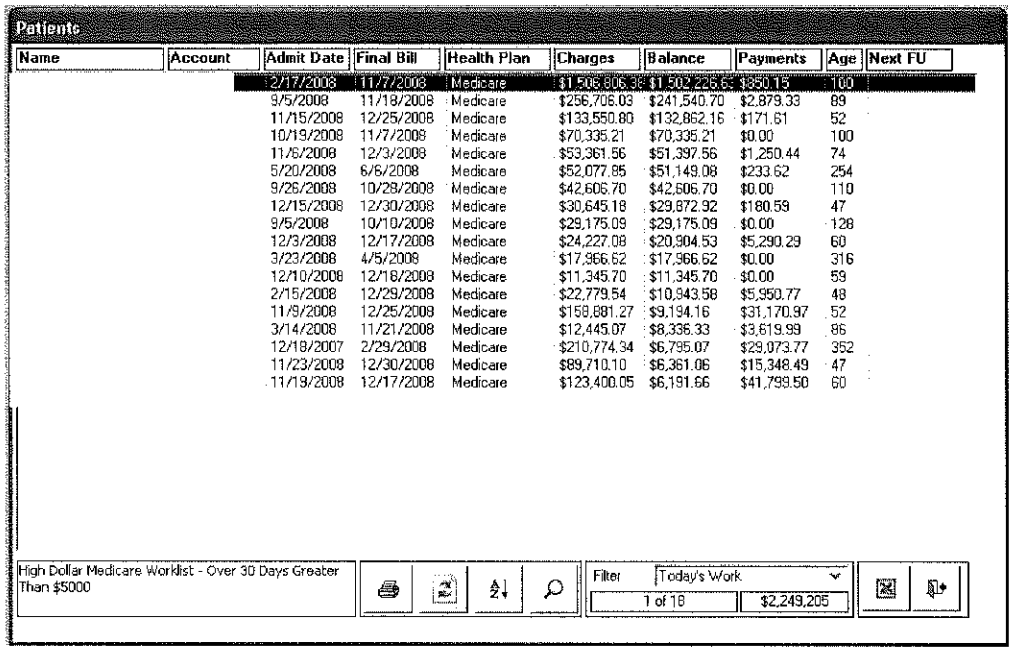
A. Click the **Worklist** button to access your individual worklist(s).



B. If responsible for multiple work lists then select the appropriate Work List.



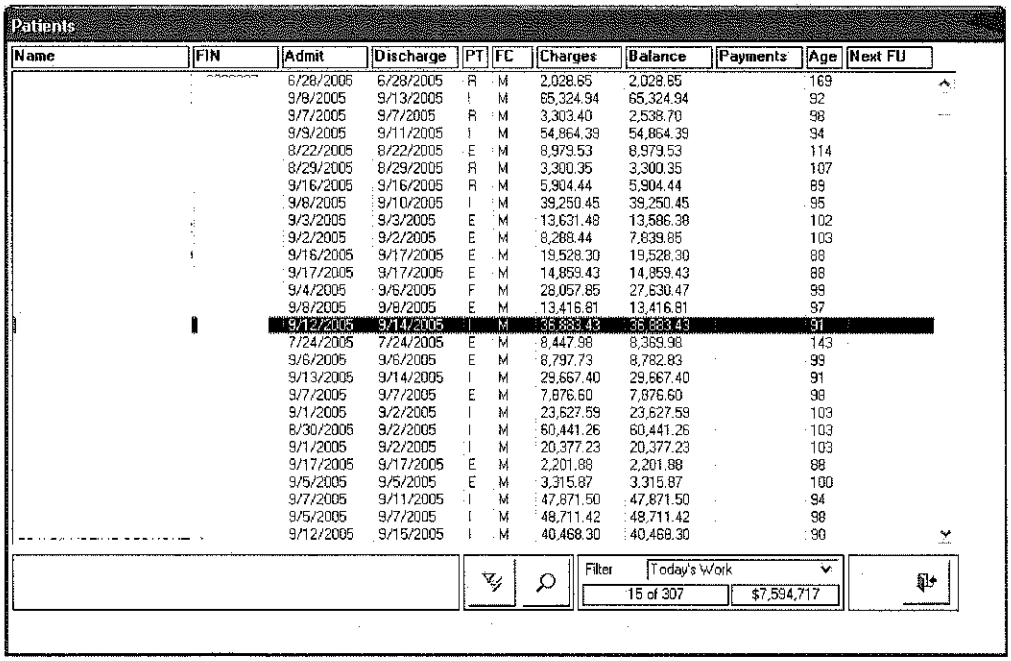
C. The selected work list will now appear in a new window.



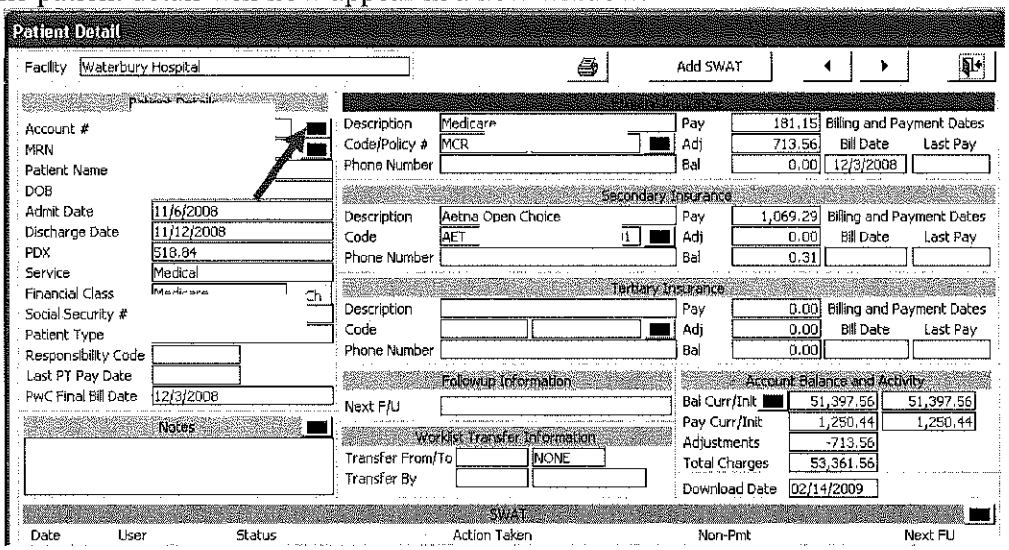
D. Select the encounter with the highest balance.

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.

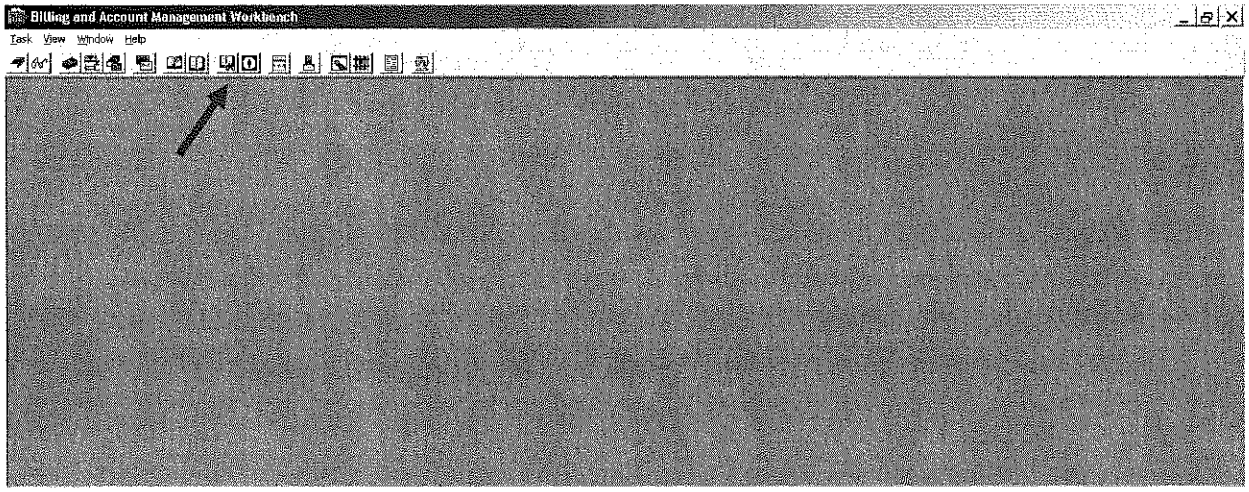


C. Click the blue box next to the Account # to copy the Cerner encounter number.

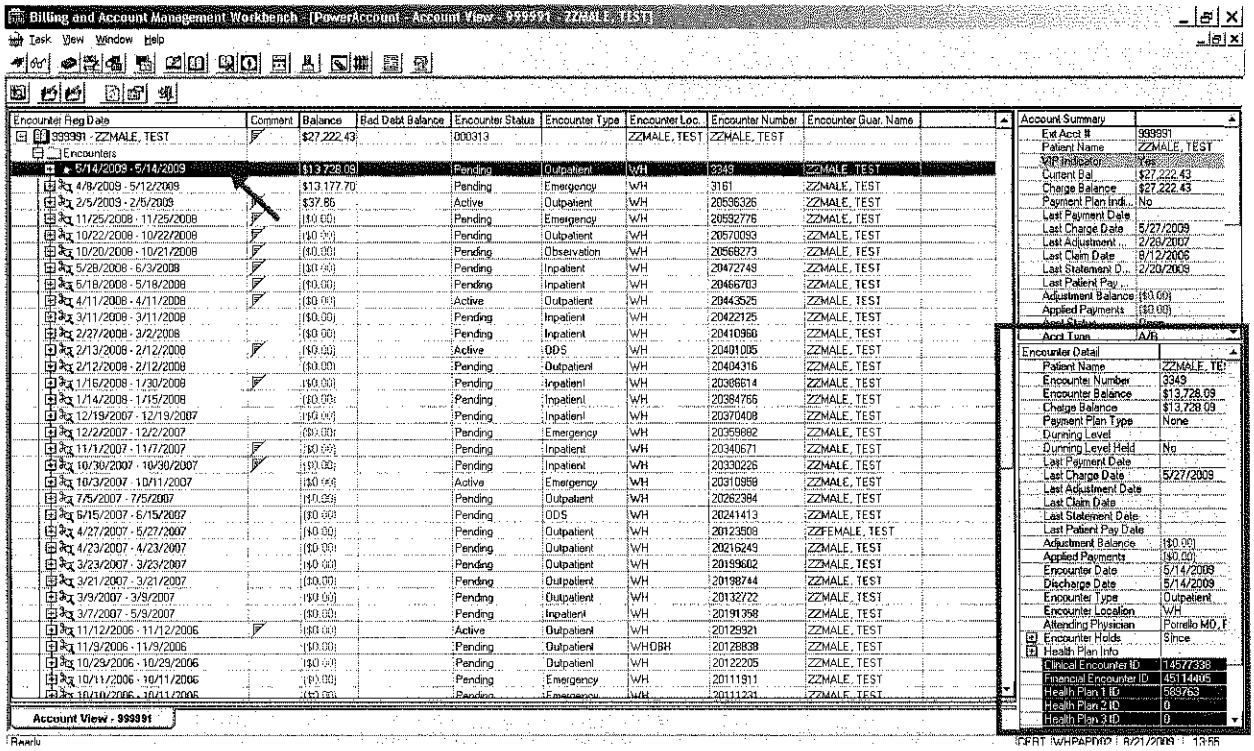
STEP 3: IDENTIFY THE PAYER AND PERTINENT PATIENT DEMOGRAPHIC INFORMATION

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).

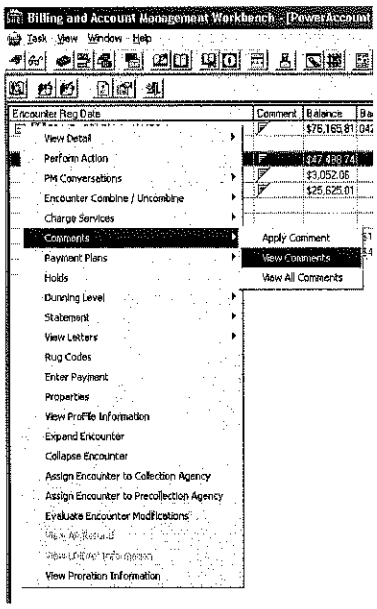
A. Open Profit PABS via the Citrix web application on the computer desktop.
B. From the opening window of Profit click the Patient Account Search icon to retrieve the encounter.



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:

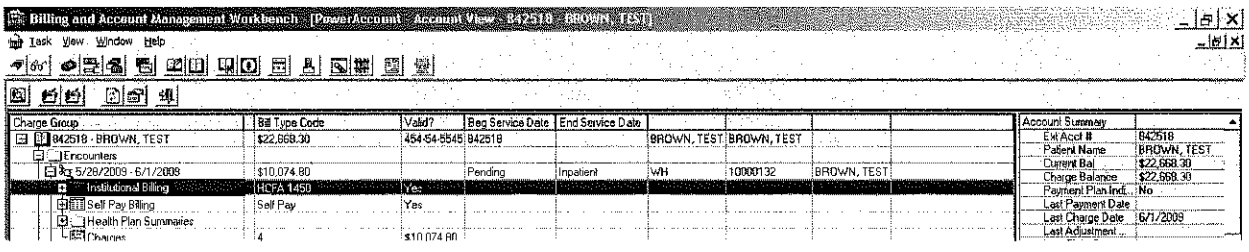
i. Quality data is in the account note
ii. The note is Readable (for examples please refer to the Readability and Appropriateness of Action Examples document) to someone outside of PAFS
iii. The Appropriate Action was taken to resolve or move the Account Forward

STEP 8: REBILL CLAIMS WHEN APPROPRIATE

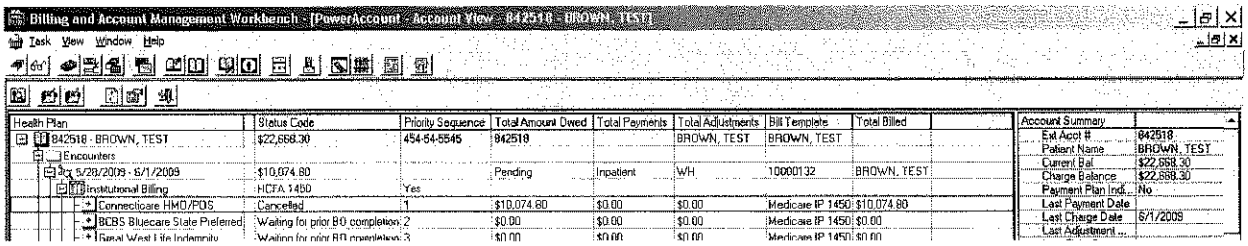
SITUATION 1: REBILL CLAIMS ELECTRONICALLY

STEPS TO REBILL CLAIM ELECTRONCIALLY:

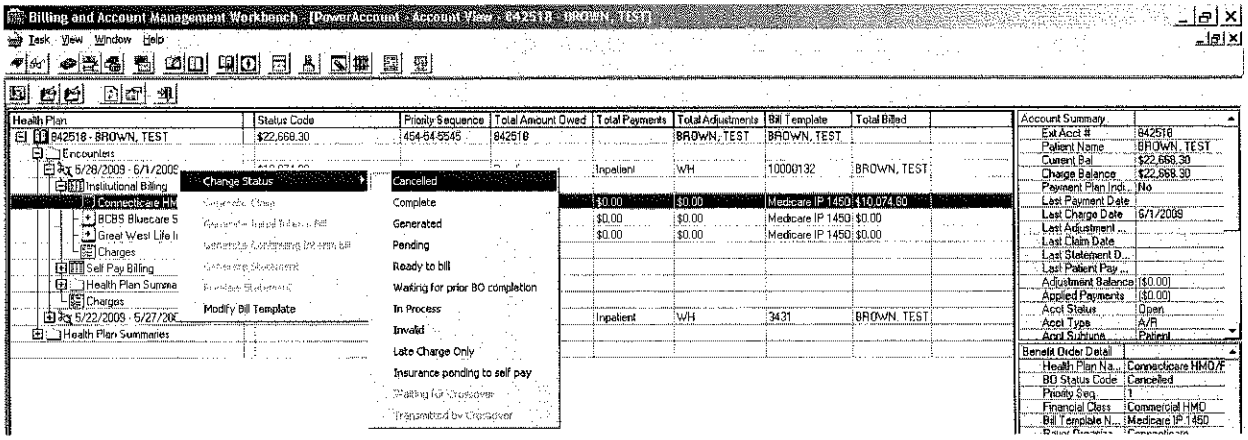
1. From the Power Accounts, select **the encounter** you wish to rebill then drill down to the appropriate billing component by clicking the + box next to the encounter.



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.

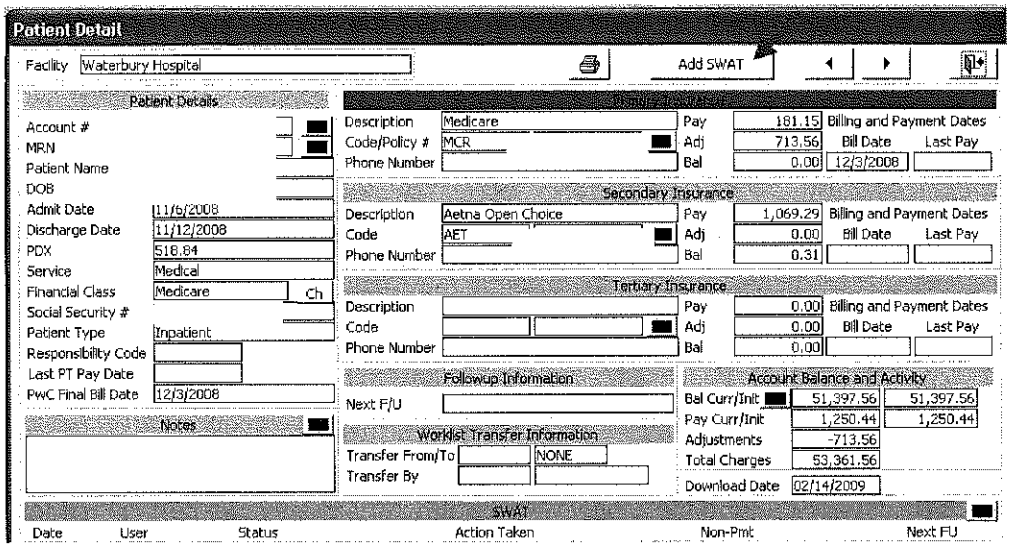
Note: If the hospital is to receive prompt payment from third parties, it is important that the initial billing statement to the third party be prompt, accurate, and clear. Reimbursements can

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

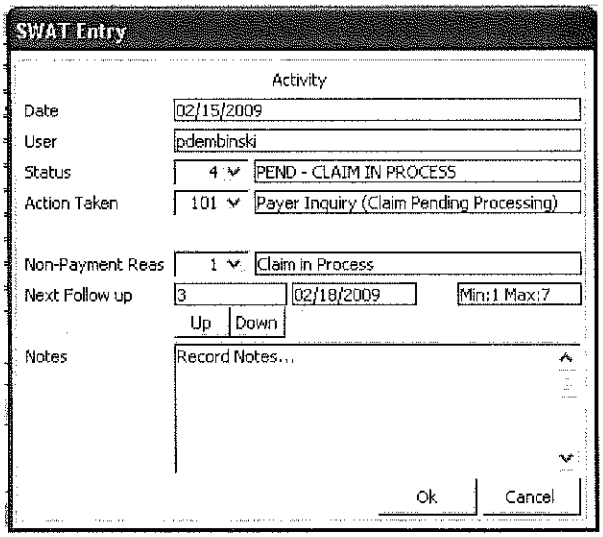
Document all information obtained from the payer inquiry in the Comments Section of the A/R Management Tool and the Patient Accounting System (Cerner).

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

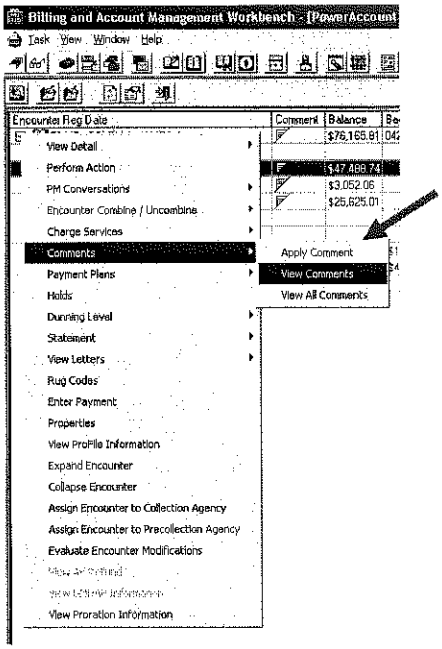
c. Non Payment Reason Code

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

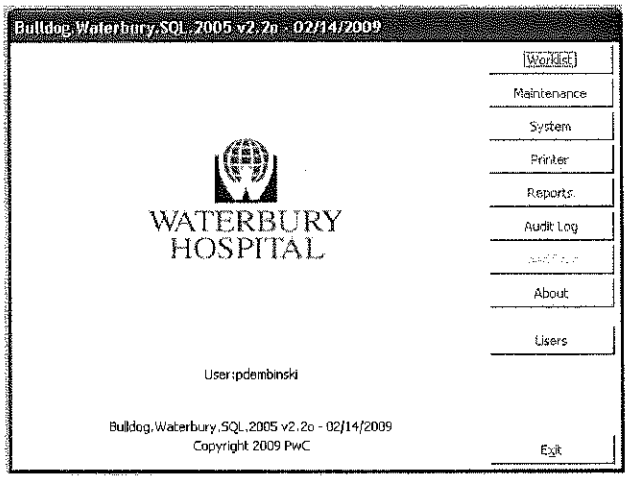
SITUATION AND RESPONSE GUIDELINES

Medicare Follow-up
All Claims Aged Greater Than
15 Days from Final Billed Date

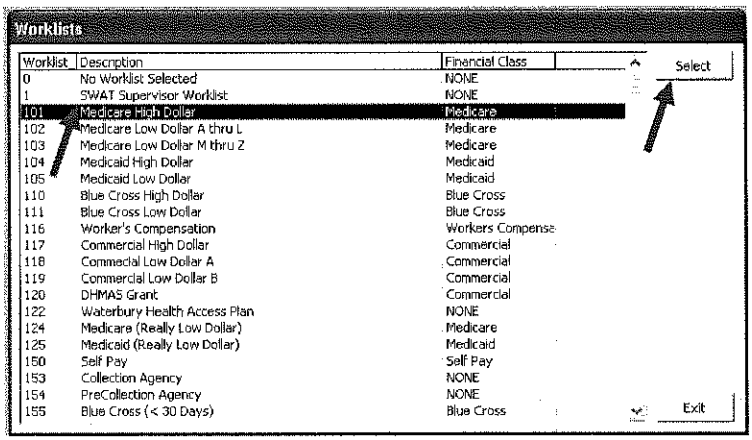
The purpose of this function is to determine claim status and obtain as much information from the payer as possible.

STEP 1: LOG INTO THE WORK LISTS MODULE THEN ACCESS THE WORK QUEUE IN THE A/R MANAGEMENT TOOL (BULLDOG)

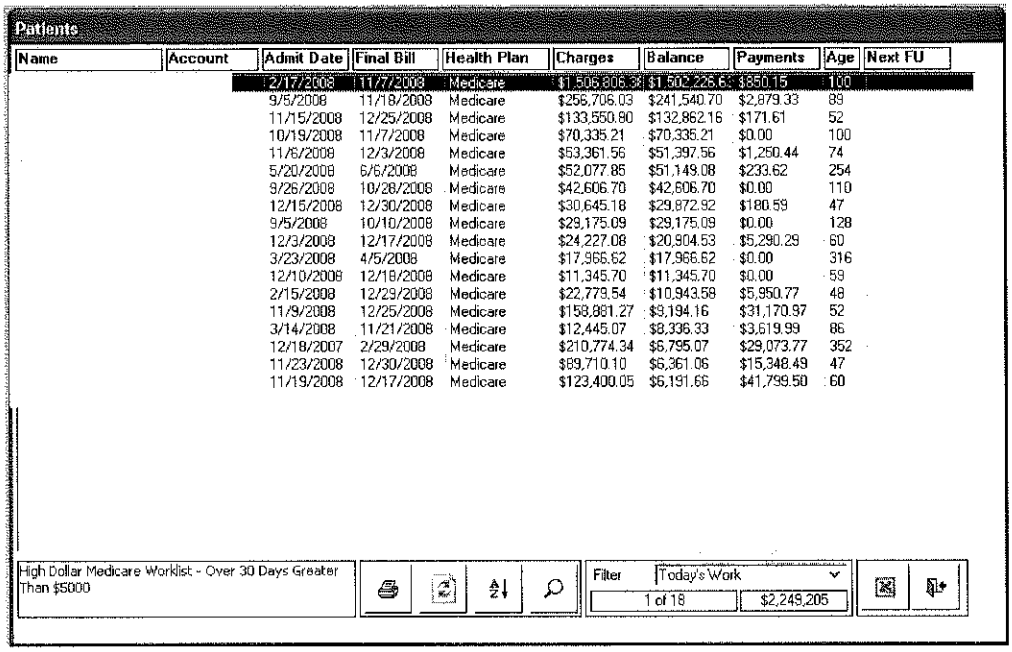
A. Click the **Worklist** button to access your individual worklist(s).



B. If responsible for multiple work lists then select the appropriate Work List.



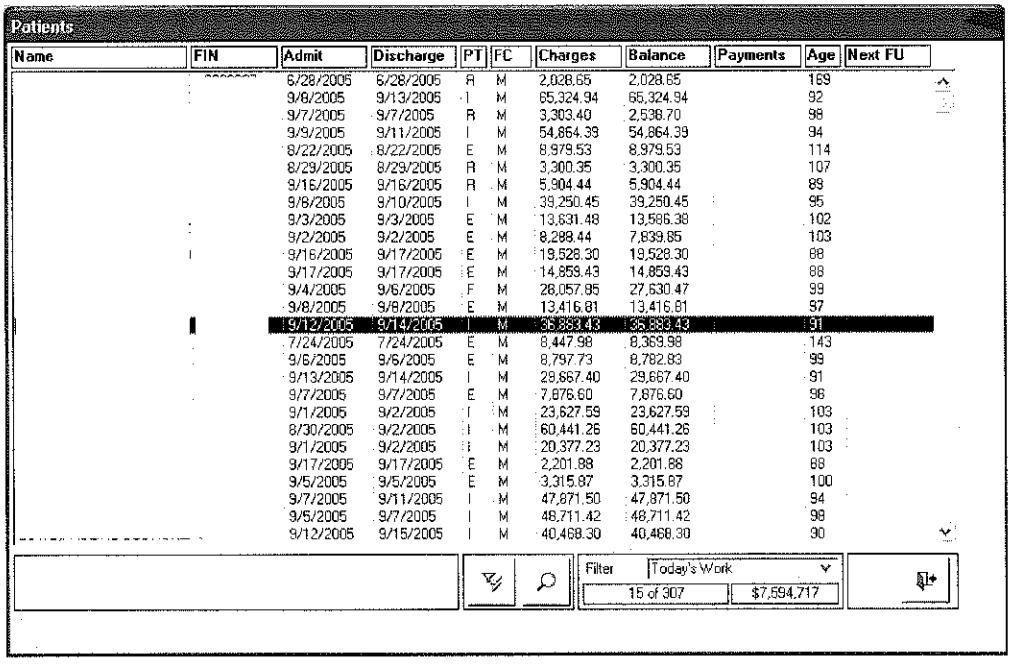
C. The selected work list will now appear in a new window.



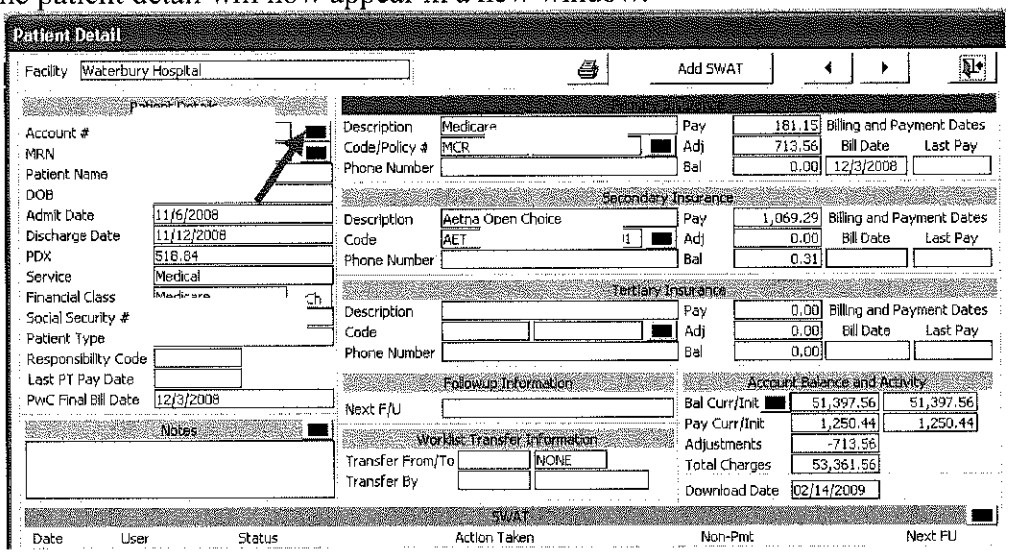
D. Select the encounter with the highest balance.

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.

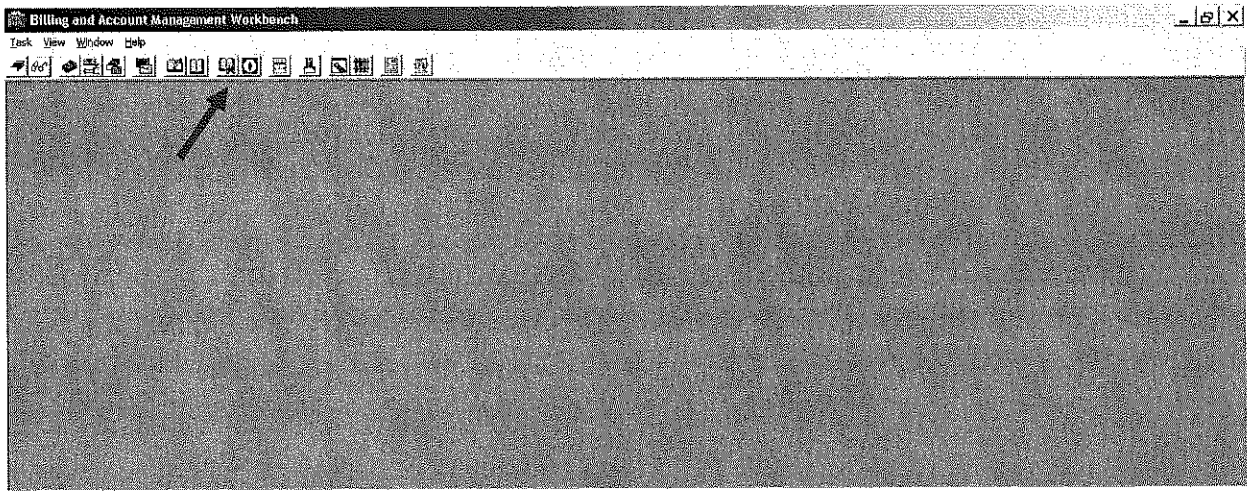


C. Click the blue box next to the Account # to copy the Cerner encounter number.

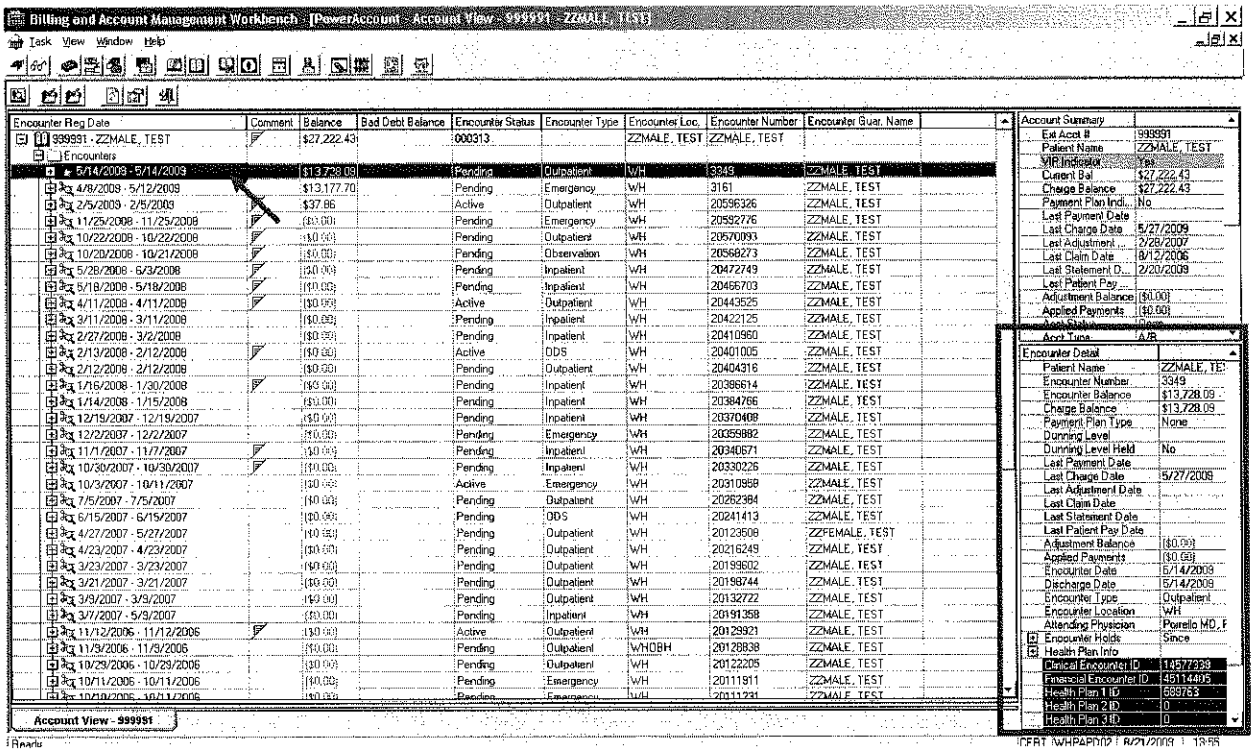
STEP 3: IDENTIFY THE PAYER AND PERTINENT PATIENT DEMOGRAPHIC INFORMATION

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).

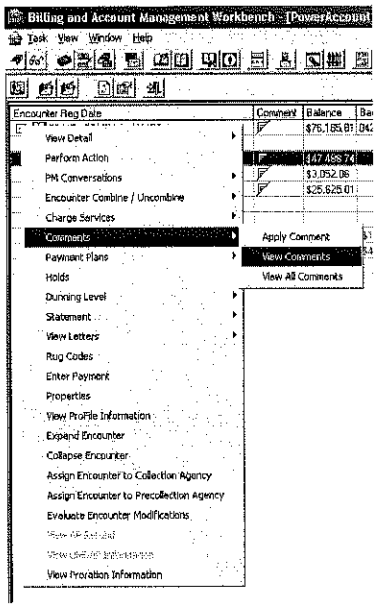
A. Open Profit PABS via the Citrix web application on the computer desktop.
B. From the opening window of Profit click the Patient Account Search icon to retrieve the encounter.



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.

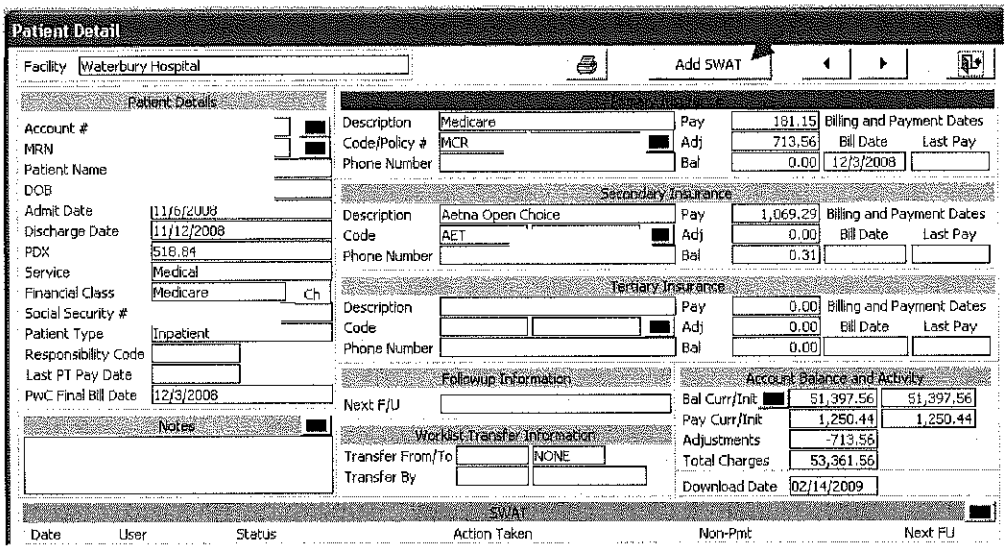
ACCOUNTS REQUIRING ESCALATION TO ASSISTANT DIRECTOR OF PATIENT ACCOUNTING
High Dollar Accounts Unresolved patient accounts with balances greater than $10,000 aged 60 days or greater from the final billed date (90 days or greater for Medicaid and SAGA) must be escalated to the Assistant Director of Patient 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

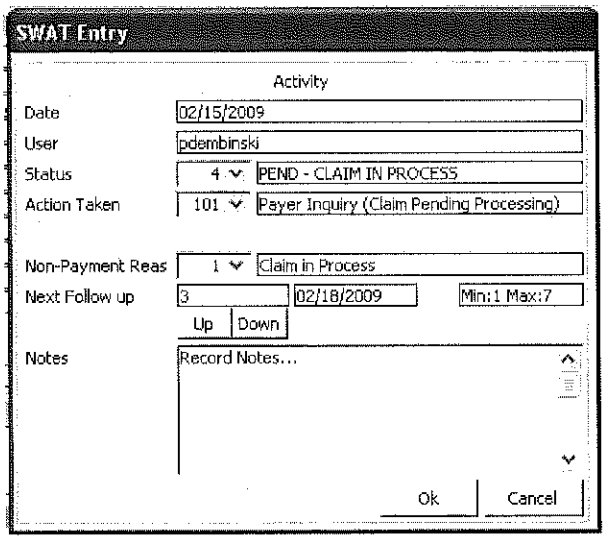
Document all information obtained from the payer inquiry in the Comments Section of the A/R Management Tool and the Patient Accounting System (Cerner).

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

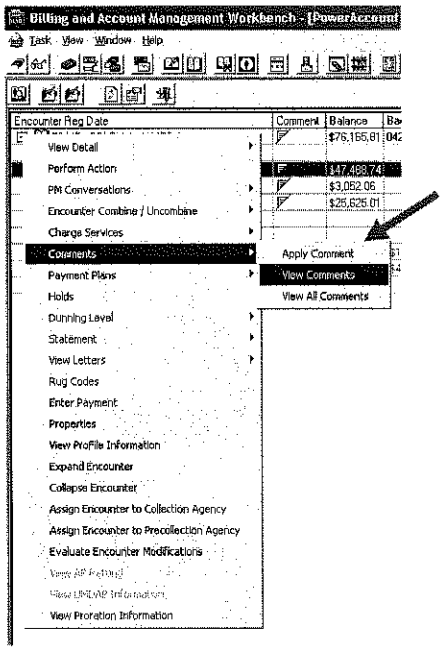
Non Payment Reason Definitions

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).

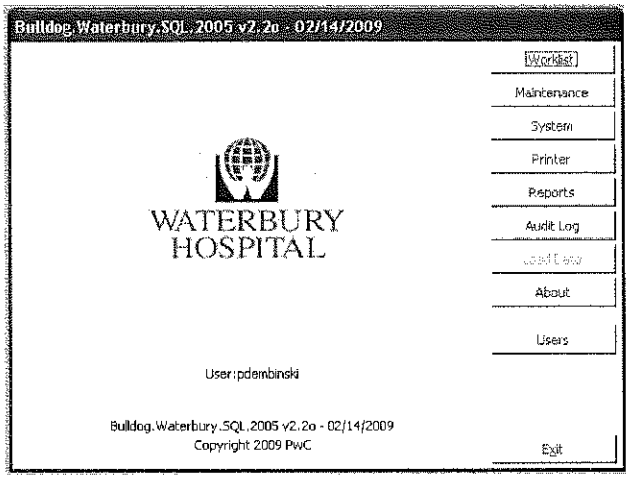
WATERBURY HOSPITAL MEDICAL CENTER

SITUATION AND RESPONSE GUIDELINES
Medicaid Follow-up
All Claims Aged Greater Than
15 Days from Final Billed Date

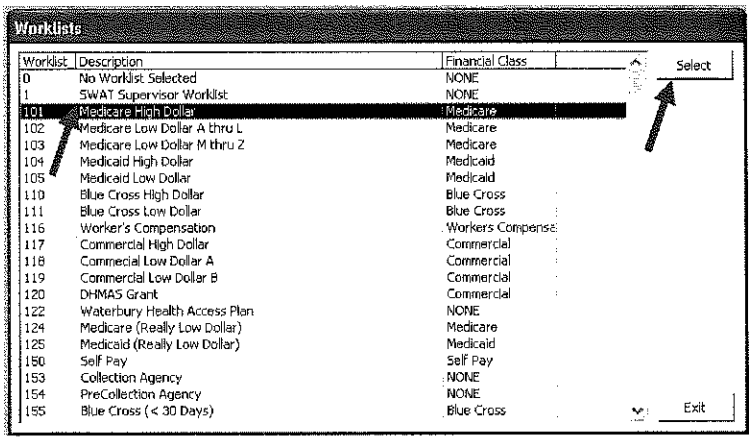
The purpose of this function is to determine claim status and obtain as much information from the payer as possible.

STEP 1: LOG INTO THE WORK LISTS MODULE THEN ACCESS THE WORK QUEUE IN THE A/R MANAGEMENT TOOL (BULLDOG)

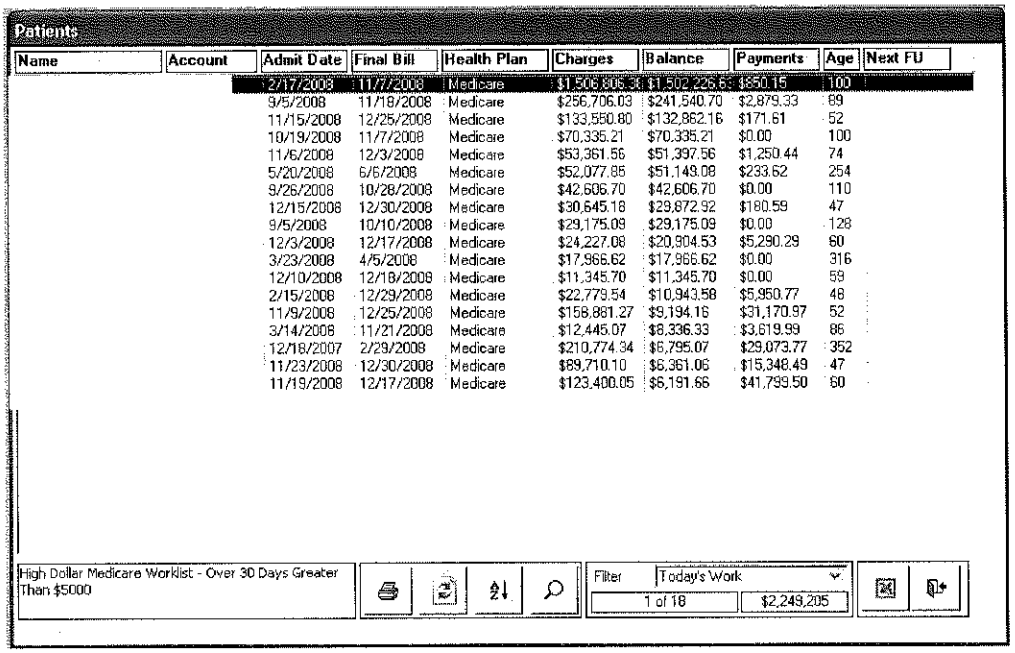
A. Click the **Worklist** button to access your individual worklist(s).



B. If responsible for multiple work lists then select the appropriate Work List.



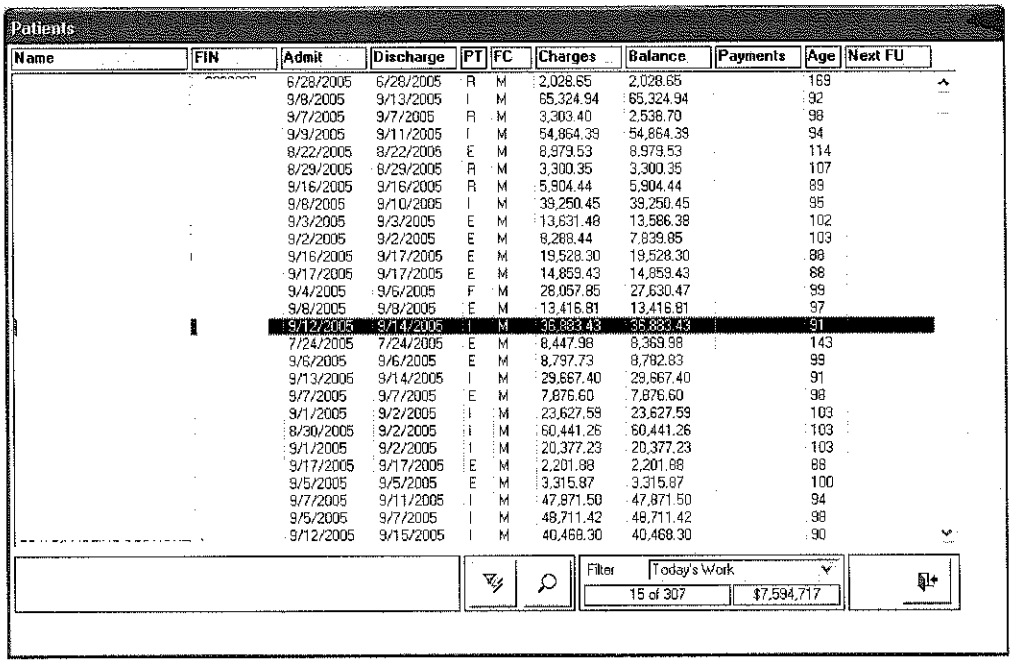
C. The selected work list will now appear in a new window.



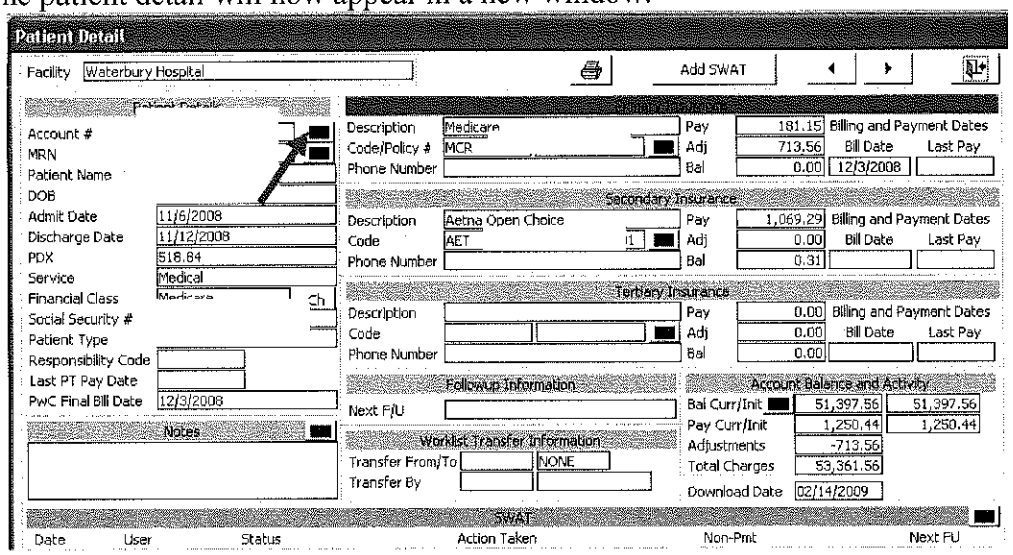
D. Select the encounter with the highest balance.

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.

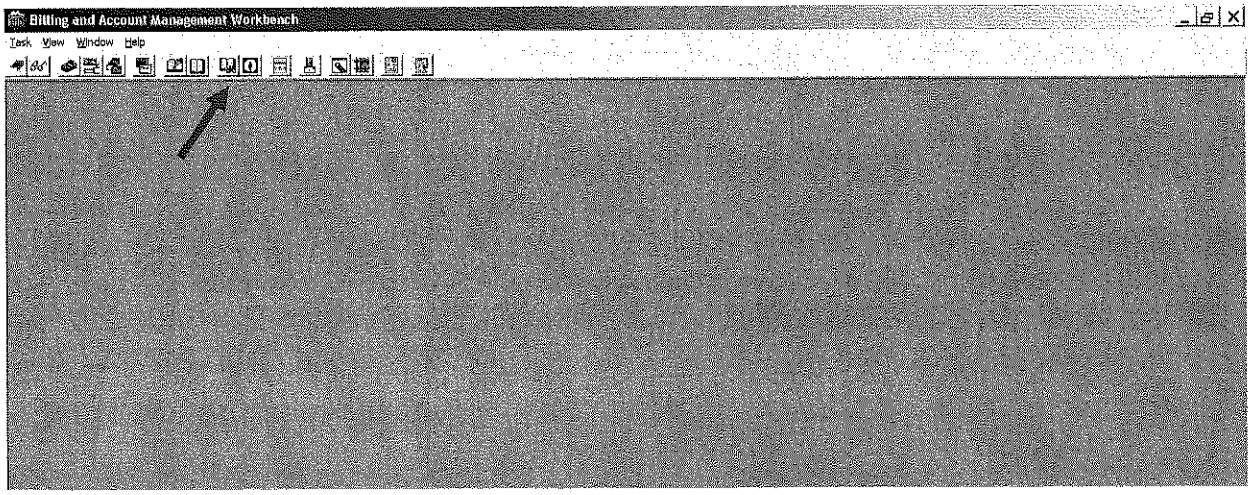


C. Click the blue box next to the Account # to copy the Cerner encounter number.

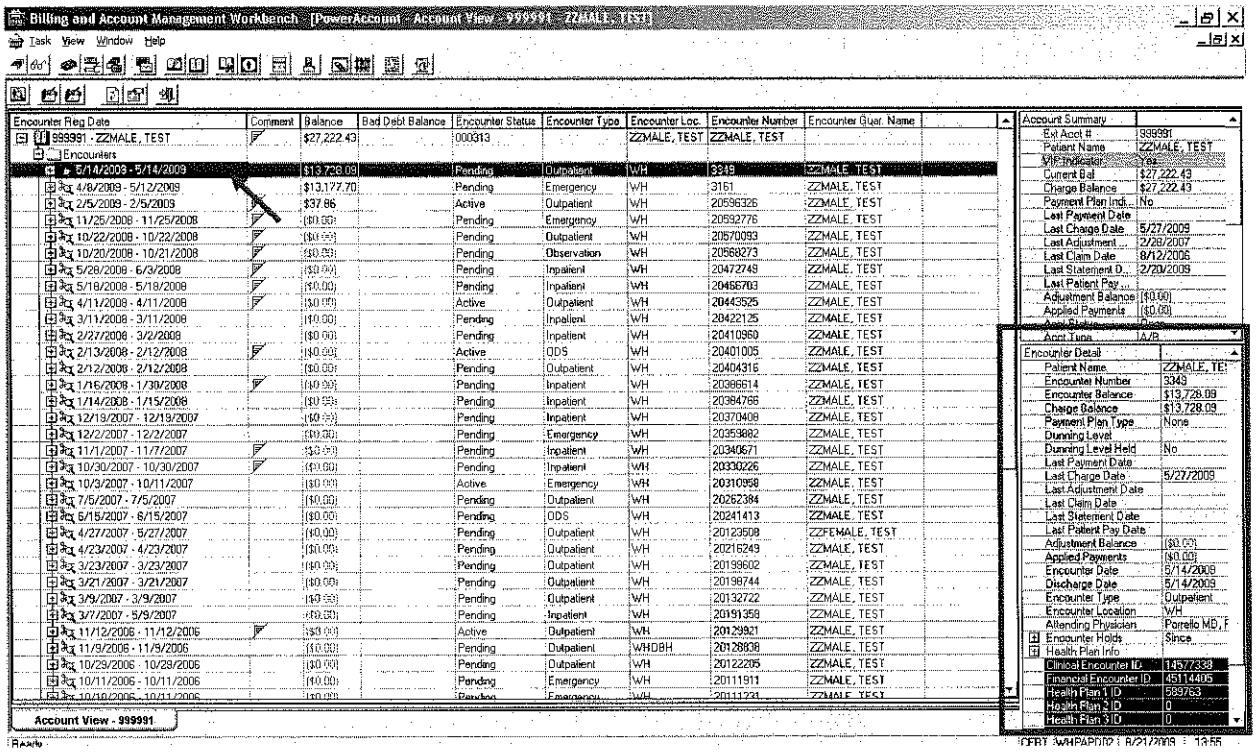
STEP 3: IDENTIFY THE PAYER AND PERTINENT PATIENT DEMOGRAPHIC INFORMATION

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).

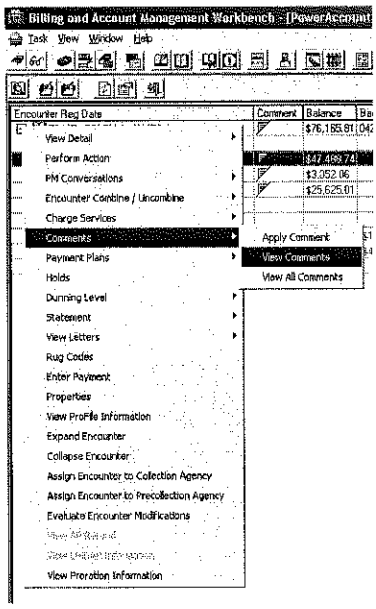
A. Open Profit PABS via the Citrix web application on the computer desktop.
B. From the opening window of Profit click the Patient Account Search icon to retrieve the encounter.



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.

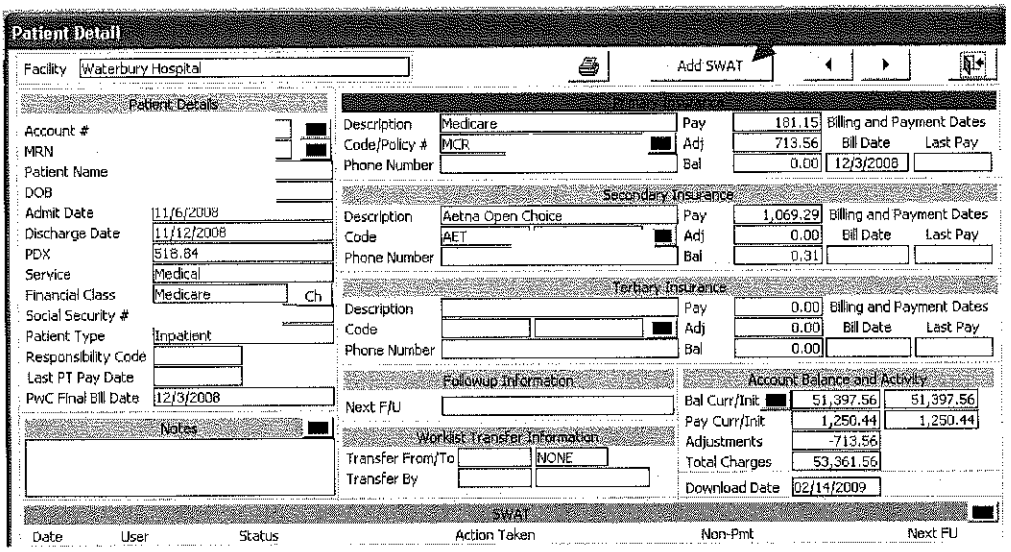
ACCOUNTS REQUIRING ESCALATION TO ASSISTANT DIRECTOR OF PATIENT ACCOUNTING
High Dollar Accounts Unresolved patient accounts with balances greater than $10,000 aged 60 days or greater from the final billed date (90 days or greater for Medicaid and SAGA) must be escalated to the Assistant Director of Patient 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

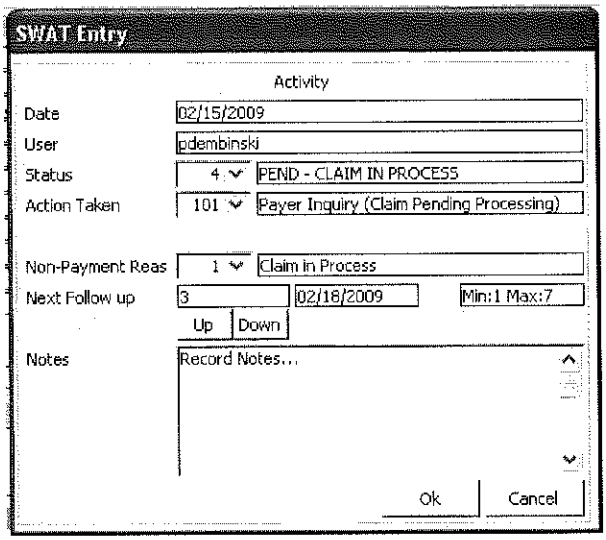
Document all information obtained from the payer inquiry in the Comments Section of the A/R Management Tool and the Patient Accounting System (Cerner).

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

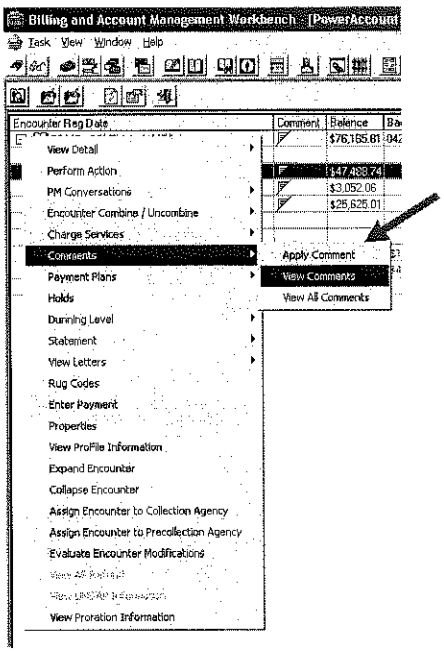
Non Payment Reason Definitions

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

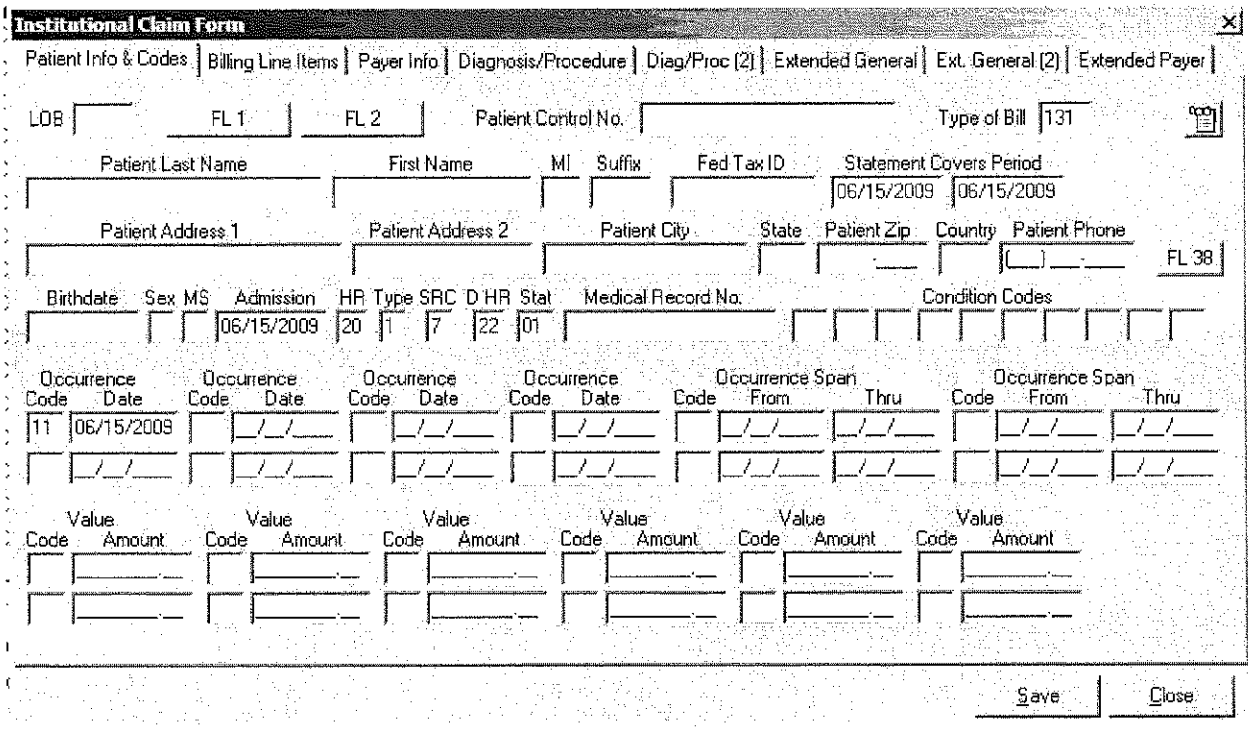
PC-Ace

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

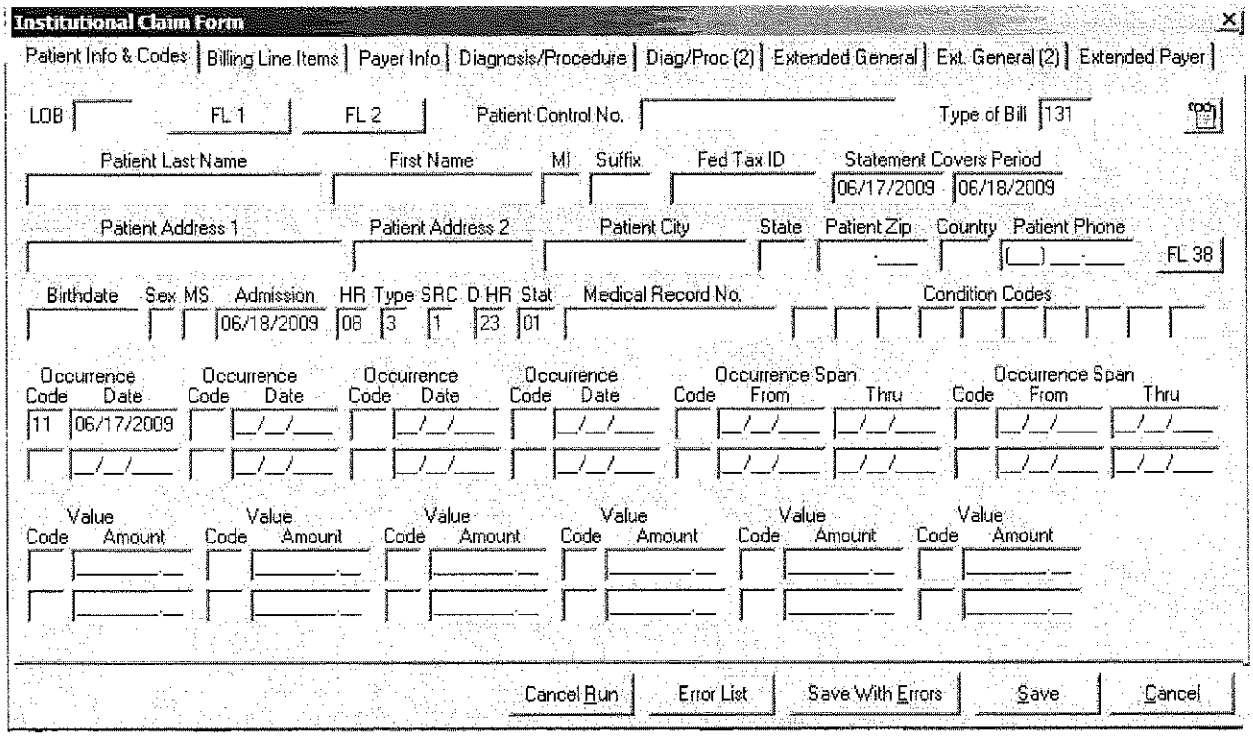
SECTION 2: ACCESS THE BILLING CLAIM

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.

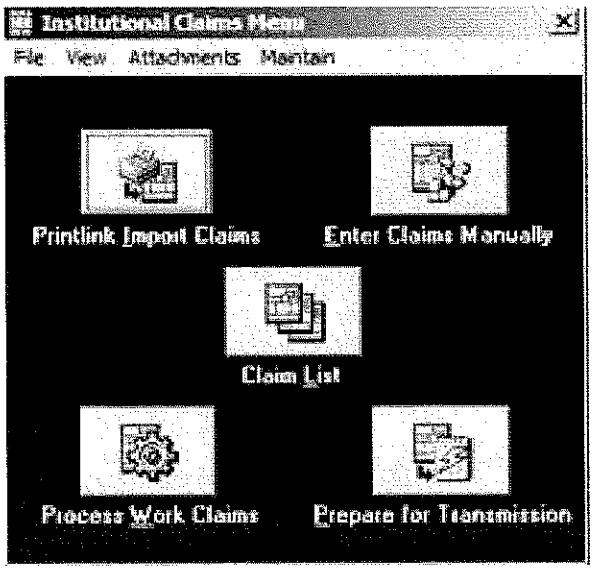


   2. If the claim is determined to be invalid, meaning it requires revisions and editing, the claim is reviewed by the Blue Cross billing staff. The claims are reviewed and worked according to the PC-Ace programmed system edits. Errored claims may be sent via email to departments for further review. A 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.

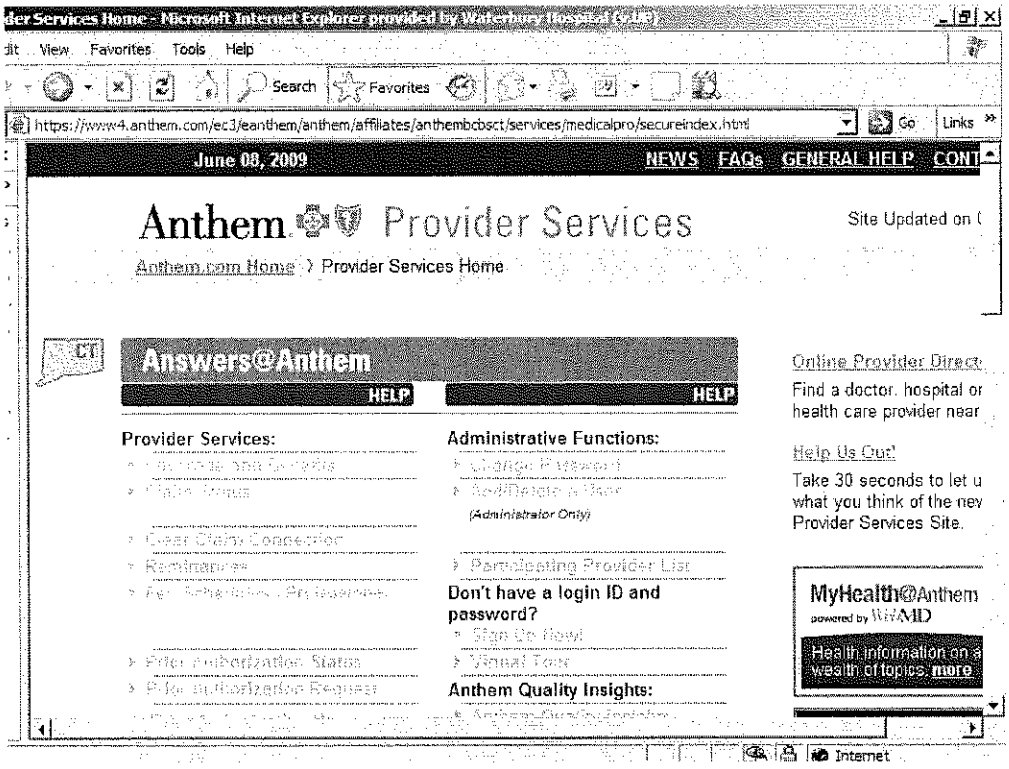
1. Double click on icon to load claims into PC-Ace. Click "Printlink Import Claims" to print list of claims and set aside last page showing the total dollar amount.



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

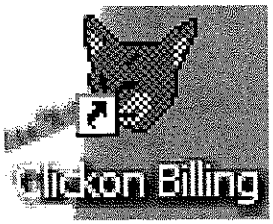
If the Edit is:	And the Issue is:	Then Complete the Following Steps:
Patient ID	Two visit claims listed for the same patient but with two different ID #s	1. Verify the correct ID # in BC system 2. Correct the patient visit in Cerner 3. Delete erroneous claim in Cerner and make note of deletion within 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.

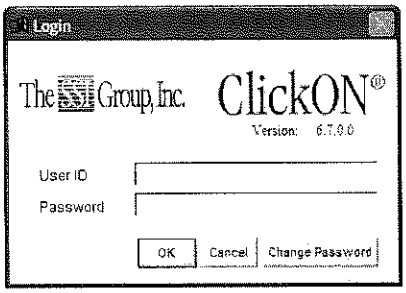
Inpatient visits with errors have higher priority and are given to Assistant Director of Patient Accounts immediately.

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.

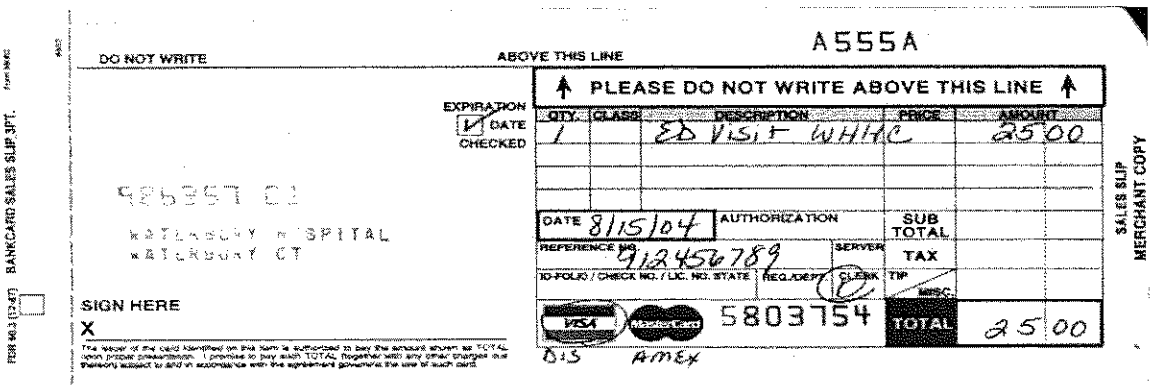
ED co-payments can be paid using cash, credit cards or checks. Co-payments will be collected from 9:30am to 5:00 pm Monday through Friday. Collection will not take place on Nights, Weekends or Holidays.

Morning Procedure

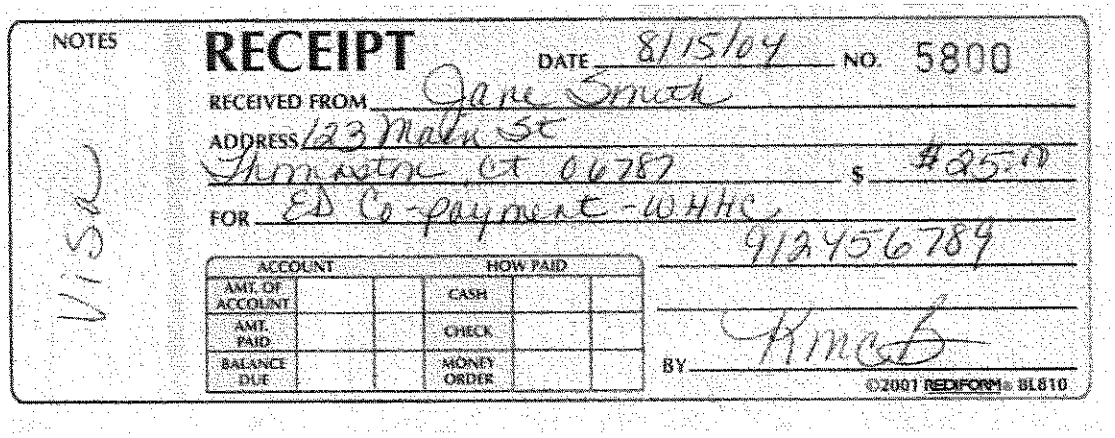
- Blue cash bag will be picked up from Cashier's office each day between 9:00 and 9:30am. Since the bag will contain the $50.00 start money, a security escort may be obtained to the ED from the cashier's office.
- Place the $50.00 start money in the cash drawer in the ED Discharge Office.
- **The register 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.

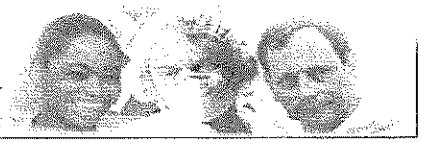
Balancing

- 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.

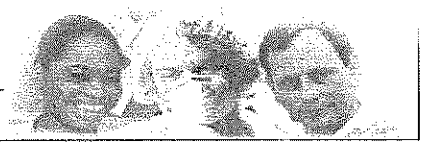
NON-SCHEDULED SERVICES – Customer Service – 203-573-7116 [see below]

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.