POLICY: CHARITY CARE		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 3
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 12/5/97 (From PAFS manual)
LAST REVIEWED: 11/11	LAST REVISED: 8/13	RETIRED:

SCOPE: Determination of when charity care is appropriate.

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

POLICY: It is the policy of Waterbury Hospital to appropriately offer charity care in situations where the responsible party for the balance due does not have the financial resources necessary to satisfy their obligation within a reasonable period of time.

1. All patients who request consideration for charity care will be required to apply for public assistance in addition to completing a charity care application unless identified as ineligible by a qualified case worker.

2. In order to be considered for charity care, full financial disclosure is required including:
   a. All sources of income available at the time of application;
   b. Assets excluding;
      i. Primary Residence;
      ii. Vehicles required for commuting to or facilitating employment;
      iii. Retirement Accounts.

3. Responsible parties with assets of $7,500 or less ($15,000 for a couple) will receive the following discounts based on their annual household income and the published federal poverty guidelines in effect at the date of application:

Income as a % of FPL	Discount
<200%	100%
<= 225%	60%
<= 275%	40%
<= 300%	20%
<= 400%	10%

4. Charity care discounts are to be applied after the 50% uninsured discount from charges.

5. Documentation required to validate declarations made on the charity care application shall include:
   a. A credit report;
   b. Most recent 1040 tax return;
   c. Copies of all bank statements to include but not limited to:
      i. Checking accounts;
      ii. Savings accounts;
      iii. Investment accounts;
      iv. Certificates of deposit
   d. Proof of income for the immediate 12 months preceding the application date.
   e. Public assistance determination.

PROCEDURE:

1. The availability of charity care will be disclosed on all dunning notices issued prior to bad debt assignment.

2. Patients who indicate they are unable to pay for services rendered will be offered charity care;

3. Financial Counselors shall evaluate each applicant's eligibility.

4. Accounts determined to be eligible for charity care discounts shall require the following authorization based on amount to be adjusted:
    a. PAFS Manager < $5,000
    b. PAFS Director $5,000 or more
    c. Chief Financial Officer $10,000 or more

5. Patients shall be issued a determination letter within 30 days of receipt of a completed charity care application.

6. Patients who do not apply for or do not qualify for charity care will be expected to pay the balance due. For uninsured patients, this will be equivalent to 50% of charges. Insured patients will be expected to pay any deductible or co-payment due in addition to 50% of non-covered charges.

7. Patient who do not enter into a payment plan or pay satisfy the balance due will be placed with a collection agency for further collection efforts. The collection agency may report the balance due to credit reporting bureaus and/or initiate legal action to resolve the debt.

Waterbury Hospital
CREDIT & COLLECTION MANUAL

DMHAS INPATIENT GRANT

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

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

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

PROCEDURE:

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

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

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

Behavioral Health will monitor DMHAS grant funding.

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

CASE # ______________________

DATE ______________________ Account # ______________________

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

Name ______________________ date of birth ______________________

Address ______________________

zip code ______________________
Phone number ______________________ social security # ______________________

Mother's information
Name ______________________ social security # ______________________
Date of birth ______________________ phone number ______________________

Address ______________________

zip code ______________________

Father's information
Name ______________________ social security # ______________________
Date of birth ______________________ phone number ______________________

Address ______________________

zip code ______________________

Guardian's information
Name ______________________ social security # ______________________
Date of birth ______________________ phone number ______________________

Address ______________________

zip code ______________________

CHURCH AFFILIATION: ______________________

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

II. HEALTH INSURANCE [ ] YES [ ] NO

Insurance ____________________ **policy #** ____________________
Insurance ____________________ **policy #** ____________________

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

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

Name	Age	Birth Date	SSN #

Total number of dependents living in household ____________

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

Address
____

Dates of employment: from ____________ to ____________

Gross weekly income ____________ net weekly income ____________

Gross income from income tax return ____________ **year** ________

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

INCOME FROM OTHER SOURCES: **spouse ___dependent___ other___**
Employer name_______________________________________phone #________________
Address
____
Dates of employment: from ________________________to ___________________
Gross weekly income _________________net weekly income _______________

MISCELLANEOUS INCOME

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

Total from All Income Sources ________________________________ $____________
____

PERSONAL / CAPITAL ASSETS

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

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

V. CURRENT DEBTS

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

CHARGE ACCOUNTS

Credit card/Store	Monthly Payment	Balance

OTHER MEDICAL BILLS

Hospital/Doctor etc.	Monthly Payment	Balance

Total outstanding debts $ ______________________

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

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

VI. CERTIFICATION

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

ACKNOWLEDGEMENT

Patient or guarantor signature ______________________________________

Witnessed by ____________________________________ **date** ______________

Address of above
____

City, town ______________________________________ State ____________

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

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

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

ATTN: PATIENT FINANCIAL SERVICES

Glossary of Terms Utilized in Financial Assistance Determinations

Definitions

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

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

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

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

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

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

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

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

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

U.S. Census Bureau

Family

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

Family household (Family)

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

Source:

Unrelated individual

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

Income

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

Waterbury Hospital Patient Access / Financial Services

CHECKLIST FOR FINANCIAL ASSISTANCE

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

_____ Proof of Debt (ALL BILLS OWED)

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

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

_____ Copy of child support check.

_____ Most current Income Tax statement

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

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

_____ Life insurance policies

_____ Car registration

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

_____ Alien registration card or other proof of alien status

_____ Other _____

_____ Other _____

_____ Other _____

Waterbury Hospital
CREDIT & COLLECTION MANUAL

FREE CARE PATIENT INFORMATION

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

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

The following signs are posted at registration points of service:

ARE YOU HAVING PROBLEMS PAYING YOUR HOSPITAL BILLS?

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

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

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

ESTA USTED TENIENDO PROBLEMAS PAGANDO LOS BILES DEL HOSPITAL?

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

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

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

CON CITA O SIN CITA:

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

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

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

ARE YOU HAVING PROBLEMS PAYING YOUR HOSPITAL BILLS?

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

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

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

ESTA USTED TENIENDO PROBLEMAS PAGANDO LOS BILES DEL HOSPITAL?

El Hospital de Waterbury le ofrece un programa llamado "Fondo de Cama Gratis" para cubrir el gasto parcial o completo a los pacientes que son internados, dado de alta o en emergencia que visitan el Hospital. Este programa solamente es para esas personas que califican. Para obtener más información, incluyendo una aplicación, por favor comuníquese con nuestra oficina de servicios al paciente en el horario indicado a continuación:

POR TELEFONO:

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

CON CITA O SIN CITA:

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

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

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

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

ARE YOU UNINSURED?

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

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

To find out if you qualify, please contact us.

PATIENT FINANCIAL SERVICES

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

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

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

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

PATIENT ASSISTANCE POLICY

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

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

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

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

DISCOUNT PROGRAMS

UNINSURED PATIENT POLICY

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

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

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

CHARITY CARE POLICY

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

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

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

Cost to Charge Alias 2003
Charity Care Non FBF 2002

SELF PAY DISCOUNT POLICIES

PROMPT PAY DISCOUNT

- Patient has **NO** insurance

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

This discount requires no financial application.

Bed Funds

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

Prompt Pay Alias 2013

SLIDING SCALE

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

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

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

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

Sliding Scale Alias 2014

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

Waterbury Hospital
CREDIT & COLLECTION MANUAL

PATIENT ASSISTANCE COMMITTEE BYLAWS

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

ARTICLE I - IDENTIFICATION

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

ARTICLE II - PURPOSE

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

ARTICLE III - MEMBERSHIP

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

SECTION 1. OFFICERS

The Officers of the Patient Assistance Committee shall be:

A. CHAIRPERSON

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

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

The Chairperson shall be a voting member of the Committee.

B. CASE PRESENTERS

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

SECTION 2. DESIGNATION

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

SECTION 3. COMPOSITION

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

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

ARTICLE IV - MEETINGS

SECTION 1. MONTHLY MEETINGS

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

SECTION 2. NOTICE OF MEETINGS

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

SECTION 3. CASE REVIEW

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

SECTION 4. QUORUM

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

SECTION 5. PRESIDING OFFICER

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

SECTION 6. INVITED GUESTS.

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

ARTICLE V - OBJECTIVES

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

ARTICLE VI - AMENDMENT TO THE RULES & REGULATIONS

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

ARTICLE VII – COMPLIANCE / RECORD-KEEPING

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

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

APPROVED:

____

VICE-PRESIDENT, FINANCE

____

CHAIRPERSON, PATIENT ASSISTANCE COMMITTEE

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

Waterbury Hospital
CREDIT & COLLECTION MANUAL

PATIENT ASSISTANCE POLICY

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

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

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

POLICY GUIDELINES:

ELIGIBILITY:

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

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

Categories of patients who would most often be eligible are:

- Self-pay patients who do not qualify for any other type of assistance programs after a financial determination.
- Patients with minimal insurance coverage who do not have the means available to resolve outstanding self-pay balances and who qualify based on financial review.
- Patients who have applied for government assistance and were denied [including timely filing denials] and either meet or do not meet all criteria for uninsured status.
- Patients who have applied for government assistance and granted, however, have open balances prior to the date granted. [These cases do not need to be presented to the committee; however, the allocation of funds is governed by the guidelines outlined in this policy. [see allocation of funds]
- Patients who would not qualify for government programs based on income or level of assets, but who would qualify based on personal hardship caused by a catastrophic medical situation.

PROCEDURE:

REFERRAL AND APPLICATION PROCESS

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

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

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

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

DECEASED PATIENTS

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

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

REVIEW AND PRESENTATION PROCESS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECORD-KEEPING

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

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

OHCA Filing Requirements

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

Annual Reporting

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

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

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

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

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

Waterbury Hospital

CREDIT & COLLECTION MANUAL

Uncompensated Care Pool Regulations
Collections by hospitals from uninsured patients

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Waterbury Hospital
CREDIT & COLLECTION MANUAL

UNINSURED PATIENT

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

SCOPE: Self pay patients who may qualify for reduction of balance if they meet the criteria for uninsured.

PURPOSE: To comply with SB 568 regarding determination of the uninsured patient by definition of Connecticut State statutes and to comply with State of Connecticut filing requirements.

POLICY:

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

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

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

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

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

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

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

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

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

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

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

Bad Debts:

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

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

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

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

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

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

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

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

Annual Reporting

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

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

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

General Statutes, To Assist With Debt Collection.

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

Date:

Dear Patient:

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

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

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

Thank you,

____

Waterbury Hospital Health Center
Patient Financial Services

SAMPLE LETTERS

DATE:______________________________

____

____

____

RE: PATIENT NAME:______________________

Encounter Number ______________________

Total Charges $______________________

Dear ______________________:

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

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

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

Very truly yours,

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

DATE:______________________________

____

____

____

RE: PATIENT NAME:______________________

Encounter Number ______________________

Total Charges $______________________

Dear ______________________:

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

Please contact us as soon as possible at ______________________.

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

Very truly yours,

The Waterbury Hospital
Patient Financial Services Department

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Patient Statement Policy

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

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

I. POLICY

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

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

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

II. DEFINITIONS

Patient Statement Cycle

The patient statement begins when the:

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

Dunning level

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

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

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

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

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

III. PROCEDURE

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

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

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

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

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

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

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

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

Waterbury Hospital

PROFIT STATEMENT CYCLE INFORMATION

When does the statement cycle start?

An initial cycle is assigned as follows:

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

What is a Dunning level?

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

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

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

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

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

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

What constitutes an acceptable payment?

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

What are the formal and informal payment plan rules?

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

Payments made below these amounts are considered to be unacceptable.

What is a global message?

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

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

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

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

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

Statement Cycle Tool

File Task Help

Statement Level Messages

Cycle Definition | Initial Cycle Setup | Path Flow

Cycle Name: Formal Payment Plan   Bill every: 1 days.

Dunning Level: Normal # 2

Bill Type: Patient Statement

Initial Cycle Message

First message for this cycle: You have entered into a form — You have entered into a formal payment plan with Waterbury Hospital. Please make your monthly

Dunning Messages

Acceptable payment: Thank you for your recent pa — Thank you for your recent payment. Please continue to honor your payment plan.

Payment received; unacceptable for encounter: Thank you for your recent pa — Thank you for your recent payment, however, it does not meet your payment arrangement guidelines. Please

Unacceptable payment: Thank you for your recent pa — Thank you for your recent payment, however, it does not meet your payment arrangement guidelines. Please

No payment: We did not receive your mon — We did not receive your monthly payment. Please contact Patient Financial Services, at 203-573-7116,

Save   Cancel

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

Statement Cycle Tool

File Task Help

Statement Level Messages

Cycle Definition | Initial Cycle Setup | Path Flow

Rules Hierarchy
- Formal Payment Plan
- Self Pay Cycle
- Worker's Compensation
- Self Pay After Insurance

Rule Properties

Available Criteria
Name
Bad Debt
Encounter Status
Encounter VIP
Financial Class
Health Plan
Informal Payment Pla
Insurance Organizati
Person VIP

Selected Criteria
Name
Formal Payment Plan

Rule Result Properties

Statement Cycle Name: Formal Payment Plan

Statement Cycle Start: Start cycle when: self pay benefit order is ready to bill.

Beginning Effective Date: 04/19/2005

Ending Effective Date: 12/31/2100 Default Statement Cycle

Save Cancel

Statement Cycle Tool

File Task Help

Statement Level Messages

Cycle Definition | **Initial Cycle Setup** | Path Flow

Rules Hierarchy
- Formal Payment Plan
- Self Pay Cycle
- Worker's Compensation
- Self Pay After Insurance

Rule Properties

Available Criteria

Name
Bad Debt
Encounter Status
Encounter VIP
Formal Payment Plan
Health Plan
Informal Payment Pla
Insurance Organizati
Person VIP

>> <<

Selected Criteria

Name
Financial Class

Select Financial Class

Selected Values
Self Pay
Pending Medicaid/SAGA

Rule Result Properties

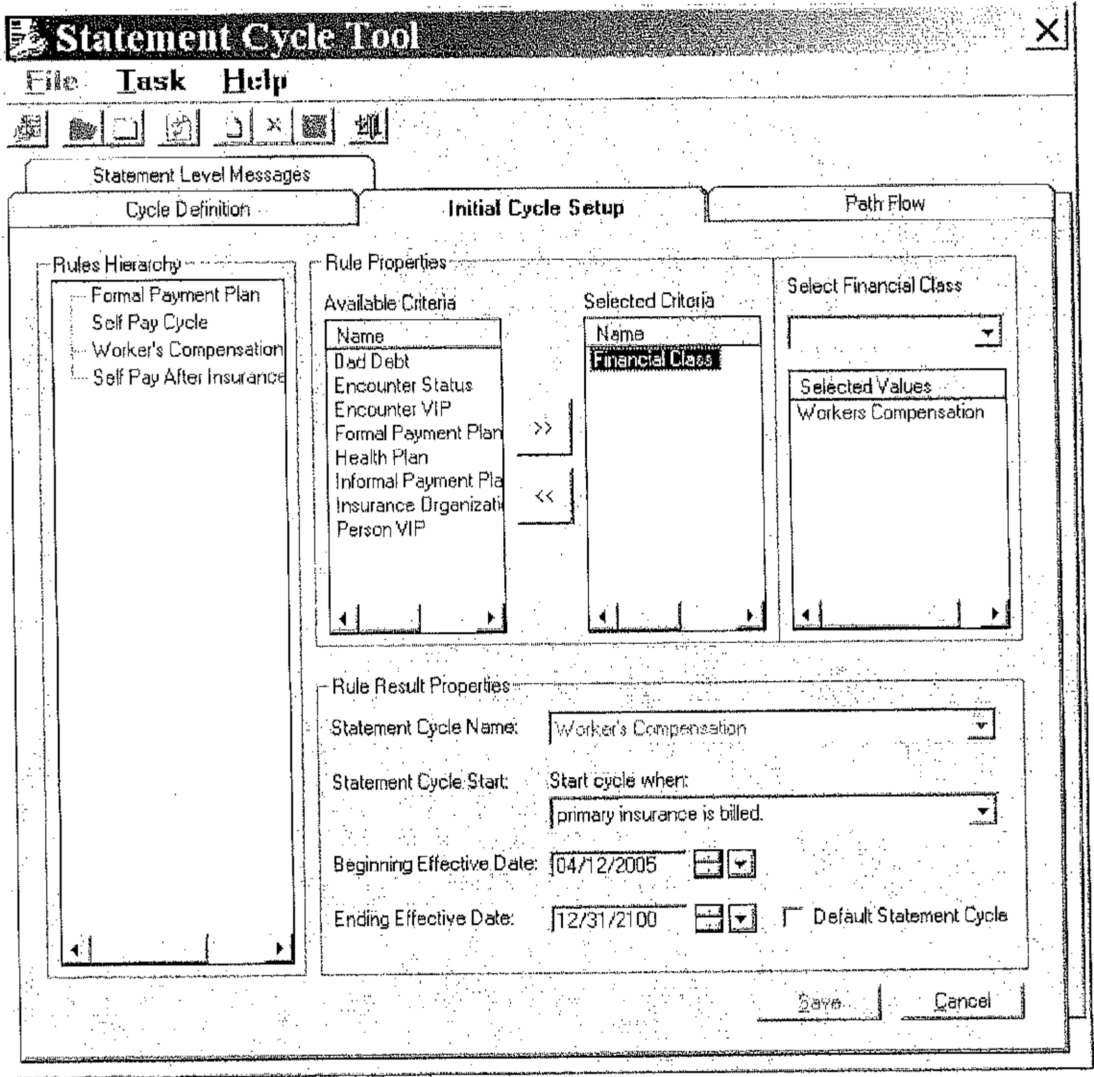
Statement Cycle Name: Self Pay Cycle

Statement Cycle Start: Start cycle when: self pay benefit order is ready to bill.

Beginning Effective Date: 07/24/2005

Ending Effective Date: 12/31/2010 Default Statement Cycle

Save Cancel


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

Statement Cycle Tool

File Task Help

Statement Level Messages

Cycle Definition | Initial Cycle Setup | Path Flow

Rules Hierarchy
- Formal Payment Plan
- Self Pay Cycle
- Worker's Compensation
- Self Pay After Insurance

Rule Properties

Available Criteria

Name
Bad Debt
Encounter Status
Encounter VIP
Formal Payment Plan
Health Plan
Informal Payment Pla
Insurance Organizati
Person VIP

>>

<<

Selected Criteria

Name
Financial Class

Select Financial Class

Selected Values
Blue Cross
Blue Cross HMO
Blue Cross PPO
Commercial Insurance
Commercial PPO
Managed Medicaid
Managed Medicare
Medicaid

Rule Result Properties

Statement Cycle Name: Self Pay After Insurance Pending DSI

Statement Cycle Start: Start cycle when: self pay benefit order is ready to bill.

Beginning Effective Date: 09/16/2005

Ending Effective Date: 09/16/2055

Default Statement Cycle

Save | Cancel

Selected Values
Blue Cross
Blue Cross HMO
Blue Cross PPO
Commercial Insurance
Commercial PPO
Managed Medicaid
Managed Medicare
Medicaid
Medicare
SAGA
Commercial HMO

PATH DEFINITION

Path Definition for Waterbury Health System

Current Cycle	Next Cycle	Count	
Final Demand			
Acceptable	Final Demand	999	
Unacceptable	Collections	0	
No Payment	Collections	0	
Collections			
Acceptable	Collections	999	
Unacceptable	Collections	999	
No Payment	Collections	999	
Formal Payment ...			
Acceptable	Formal Payment Pl...	999	
Unacceptable	Final Demand	2	
No Payment	Final Demand	0	
Worker's Compe...			
Acceptable	Precollections	3	
Unacceptable	Worker's Compen...	999	
No Payment	Worker's Compen...	999	
Precollections			
Acceptable	Precollections	999	
Unacceptable	Precollections	999	
No Payment	Precollections	999	
Self Pay Cycle			
Acceptable	Precollections	0	
Unacceptable	Precollections	0	
No Payment	Precollections	0	
Manual Stateme...			
Acceptable	Manual Statement...	999	
Unacceptable	Final Demand	2	
No Payment	Final Demand		***
Self Pay After In...			
Acceptable	Precollections	0	
Unacceptable	Precollections	0	
No Payment	Precollections	0	

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

FORMAL PAYMENT PLAN CHEAT SHEETS

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

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

When a formal plan is set up the following messages

Formal Payment Plan Set-Up

Formal Payment Plan

This tool is used to create/modify a formal payment plan.

Guarantor Information

Name: NERI, RICHARD R

Address: home(2)

41 PHYLLIS AVE
WATERBURY, CT 06708
USA

Encounter Information

Date of Service: 2/27/2007

Last Payment Date: 8/24/2007

Current Balance: $1,278.65

Tasks

Apply Changes

Cancel Changes

View History

New Plan Definition

Field	Value
Total Amount Owed:	$1,278.65
Installment Amount:	
Start Date:	05/29/2007
Cycle Length:	30
Due Day:	
First Statement Date:	05/29/2007
Plan Status:	Reset to wait for next paymen
Number of Payments:	18
Duration Plan:	11/18/2008

Current Payment Plan Information

Field	Value
Original Amount:	$1,278.65
Installment Amount:	$86.00
Start Date:	5/29/2007
Cycle Length:	30
Due Day:	0
First Statement Date:	5/29/2007
Plan Status:	Reset to wait for next payment
Number of Payments:	18
Due Date:	11/18/2008

Suggested Values

Installment Amount	Number of Payments	Estimated End Date
$255.73	5	2/25/2008

FORMAL PLAN MESSAGES

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

MANUAL STATEMENT CYCLE MESSAGES

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

FINAL DEMAND MESSAGES

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

It is important to remember the following when researching statements:

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

Account #:	Amount Due:
190329	1364.65
Statement Date:	Date Due:
07-29-2007	08-28-2007

STATEMENT CYCLE MATRIX

Special Rules:

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

STATEMENT CYCLE MATRIX

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

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

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Bad Debt - Collection Agency Referral

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

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

I. POLICY

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

II. PROCEDURE

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

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

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

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

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

Waterbury Hospital is currently contracted with two collection agencies:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Waterbury Hospital
CREDIT & COLLECTION MANUAL

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

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

I. POLICY

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

II. PROCEDURE

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

III. FAIR DEBT COLLECTION PRACTICES ACT (FDCPA) ADDENDUM

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

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

Table of Contents

§ 801 Short title
§ 802 Congressional findings and declaration of purpose
§ 803 Definitions
§ 804 Acquisition of location information
§ 805 Communication in connection with debt collection
§ 806 Harassment or abuse
§ 807 False or misleading representations
§ 808 Unfair practices
§ 809 Validation of debts
§ 810 Multiple debts
§ 811 Legal actions by debt collectors

§ 812 Furnishing certain deceptive forms
§ 813 Civil liability
§ 814 Administrative enforcement
§ 815 Reports to Congress by the Commission
§ 816 Relation to State laws
§ 817 Exemption for State regulation
§ 818 Exception for certain bad check enforcement programs operated by private entities
§ 819 Effective date

§ 801 15 USC 1601 note

§ 801. Short Title

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

§ 802. Congressional findings and declaration of purpose

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

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

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

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

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

§ 803. Definitions

As used in this title—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 804. Acquisition of location information

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

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

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

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

(4) not communicate by post card;

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

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

§ 805. Communication in connection with debt collection

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

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

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

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

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

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

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

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

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

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

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

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

§ 806. Harassment or abuse

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

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

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

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

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

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

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

§ 807. False or misleading representations

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

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

(2) The false representation of—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 808. Unfair practices

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

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

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

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

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

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

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

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

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

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

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

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

§ 809. Validation of debts

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

(1) the amount of the debt;

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

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

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

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

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

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

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

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

§ 810. Multiple debts

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

§ 811. Legal actions by debt collectors

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

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

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

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

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

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

§ 812. Furnishing certain deceptive forms

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

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

§ 813. Civil liability

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

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

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

(B) in the case of a class action,

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

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

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

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

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

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

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

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

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

§ 814. Administrative enforcement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 815. Reports to Congress by the Commission

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

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

§ 816. Relation to State laws

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

§ 817. Exemption for State regulation

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

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

(a) In General.—

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

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

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

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

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

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

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

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

(iii) does not exercise independent prosecutorial discretion;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 819. Effective date

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

Approved: ______________________________ ____________________
Date

Approved: ______________________________ ____________________
Date

Approved: ______________________________ ____________________
Date

Waterbury Hospital
CREDIT & COLLECTION MANUAL

Medicare Bad Debt Referrals

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

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

I. POLICY

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

II. PROCEDURE

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

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

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

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

Waterbury Hospital
CREDIT & COLLECTION MANUAL

CMS Reg - Medicare Bad Debt Guidelines

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

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

302. DEFINITIONS

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

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

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

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

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

304. BAD DEBTS UNDER MEDICARE

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

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

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

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

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

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

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

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

306. BAD DEBTS RELATING TO NONCOVERED SERVICES OR TO NONBENEFICIARIES

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

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

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

308. CRITERIA FOR ALLOWABLE BAD DEBT

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

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

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

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

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

310. REASONABLE COLLECTION EFFORT

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

A. Collection Agencies.--A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal

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

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

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

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

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

312. INDIGENT OR MEDICALLY INDIGENT PATIENTS

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

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

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

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

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

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

314. ACCOUNTING PERIOD FOR BAD DEBTS

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

316. RECOVERY OF BAD DEBTS

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

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

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

320. METHODS OF DETERMINING BAD DEBT EXPENSE

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

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

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

322. MEDICARE BAD DEBTS UNDER STATE WELFARE PROGRAMS

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

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

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

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

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

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

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

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

326. APPLYING COLLECTIONS FROM BENEFICIARIES

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

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

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

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

331. CREDIT CARD COSTS

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

332. ALLOWANCE TO EMPLOYEES

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

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

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

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

Approved: ______________________ ______________
Date

Approved: ______________________ ______________
Date

Approved: ______________________ ______________
Date

Waterbury Hospital

POLICY AND PROCEDURES

Medicare Bad Debt Reporting Policy

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

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

I. POLICY

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

II. PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

WATERBURY HOSPITAL

POLICIES AND PROCEDURES

Quality Assurance (QA) Review Program

DESCRIPTION/OVERVIEW:

This procedure describes the Quality Assurance Review Process for the Billing Staff.

AREAS OF RESPONSIBILITY:

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

GUIDELINES:

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

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

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

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

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

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

OVERALL SCORE CALCULATION:

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

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

ACCOUNT SELECTION:

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

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

PROCEDURE:

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

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

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

ATTACHMENTS:

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

WATERBURY HOSPITAL HEALTH CENTER

POLICIES AND PROCEDURES

Quality Assurance (QA) Review Program:
Review Indicators

PURPOSE:

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

REVIEW INDICATORS:

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

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

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

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

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

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

Waterbury Hospital

POLICY AND PROCEDURES

Billing Quality Assurance

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

I. POLICY

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

II. PROCEDURE

Clean Claim Pass Rate

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

Billing Edits

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

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

Productivity Metrics

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

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

WATERBURY HOSPITAL

POLICIES AND PROCEDURES

Quality Assurance (QA) Review Program

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

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

GUIDELINES:

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

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

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

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

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

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

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

<u>**OVERALL SCORE CALCULATION:**</u>

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

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

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

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

ACCOUNT SELECTION:

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

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

PROCEDURE:

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

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

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

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

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

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

ATTACHMENTS:

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

WATERBURY HOSPITAL HEALTH CENTER

POLICIES AND PROCEDURES

Quality Assurance (QA) Review Program:
Review Indicators

PURPOSE:

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

REVIEW INDICATORS:

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

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

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

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

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

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

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

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

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

WATERBURY HOSPITAL HEALTH CENTER

POLICIES AND PROCEDURES

Quality Assurance (QA) Review Program:
Industry Standards

PURPOSE:

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

BEST PRACTICE EXAMPLES:

1) Best Practice Note:

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

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

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

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

2) Unsatisfactory Note:

1. Payer inquiry; claim in process

What is missing:

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

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

What is missing:

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

3) Zero Credit Note:

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

What is missing:

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

POLICY: UNINSURED PATIENT DISCOUNT		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 2
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 4/13
LAST REVIEWED:	LAST REVISED:	RETIRED:

SCOPE: All PFS and Patient Access staff.

PURPOSE: To align balances due from uninsured patients with payments received from insurance carriers.

POLICY:

1. Uninsured patients shall be entitled to a discount of 50% of charges.
2. This discount shall be posted to the patient's account at the time a final bill is generated.
3. Any additional discounts such as prompt pay or charity care shall be calculated after the uninsured discount is applied.
4. Accounts forwarded to collections shall be placed net of the uninsured discount.

PROCEDURES:

1. Posting of the uninsured discount shall be automated through the HIS in place at the time the bill is generated.
2. In the event insurance coverage is identified after the uninsured adjustment has been posted, the adjustment shall be reversed and any applicable contractual allowance posted as per standing protocol for the specific payer.

POLICY: PROMPT PAY DISCOUNT		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 2
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 4/13
LAST REVIEWED:	LAST REVISED:	RETIRED:

SCOPE: Billing practices for uninsured patients.
PURPOSE: To establish an equitable method of billing uninsured patients considering insurance reimbursement practices.

POLICY:

1. In order to reduce the cost of collections and increase the availability of working capital, a 25% discount will be offered to patients who pay the estimated balance due on or before the date of service.

2. Uninsured patients shall receive this discount in addition to any uninsured discounts effective at the time of service.

3. Insured patients shall receive this discount if payment is received at time of service based on an estimate of their out-of-pocket expenses. This discount shall be extended to any additional balances due in the event the estimated balance is less than the actual amount due after the claim has been paid by the insurance carrier provided the remaining balance is paid within 30 days of the first patient bill.

PROCEDURES

1. Non-urgent patients shall be notified of their estimated balance due prior to receiving services to include open AR and unresolved bad debt balances.

2. Urgent patients shall be notified of their estimated balance due, including unresolved active AR and bad debt, after their medical condition has been stabilized.

3. A 25% discount shall be extended to any portion of the debt paid by the patient upon notification of the total estimated balances due to the hospital.

4. Upon collection of payment, a receipt for the amount tendered will be issued with the discount clearly documented.

5. The white copy of the receipt will be given to the patient for their records.

6. The pink copy will be forwarded to the cashier with the funds for posting both payment and the discount.

7. The yellow copy will be retained in the receipt book at the department.

8. Upon depletion of a receipt, it will be the department's responsibility to archive these books in accordance with existing document retention policies.