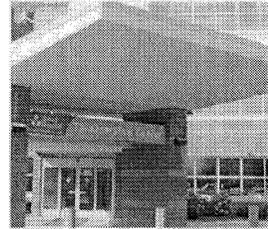


# Bristol Hospital Uncompensated Care Policies & Procedures

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**Statement of Financial Policy**

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



## Policy & Procedure

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

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Page: 1 of 3

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### Financial Assistance

#### Policy:

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

#### Definition:

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

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

#### GUIDELINES AND ALLOCATION PLAN

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

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

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

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

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

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

#### **ADMINISTRATIVE RESPONSIBILITY**

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

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

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

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

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

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

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

	
<b>Title: Charity Care and Patient Assistance Policy</b>	Approved by: Revenue Cycle Committee Date approved: January 19, 2012 Responsible Party: Finance
<b>Applies to:</b> <input checked="" type="checkbox"/> All  <input type="checkbox"/> Inpatient <input type="checkbox"/> Peri-op <input type="checkbox"/> OP/Amb Care <input type="checkbox"/> Home Care <input type="checkbox"/> Psych  <input type="checkbox"/> Department: _____	

All policies and procedures represent our current knowledge and judgment regarding the issue covered by this policy. If you can think of a better way to handle the issue covered in this policy and procedure, or if this policy and procedure needs to be revised to reflect changes that have occurred, please bring your issues/concerns forward so that we may consider improving this policy and procedure accordingly.

**PURPOSE**

The purpose of this Plan is to define a process for ensuring that patients pay amounts for their care, which they can afford

**POLICY STATEMENTS**

BHHCG recognizes that the burden of health care costs on individuals is a national crisis. Decades of Hospital pricing, distorted by the unique billing requirements imposed by private and governmental payers and regulations, has resulted in a charge structure which unfairly burdens the individuals and families without or with limited insurance. BHHCG wishes to correct this unfairness by ensuring that all uninsured patient's charges are limited and capped at Medicare's payment levels. That discount level is defined as the ratio of Medicare Charge to Payments and listed on the most recent OHCA filing. The most current discount is 71%. When a patient has no insurance, their bill will be immediately reduced by that percentage discount, using the charity care uninsured allowance code.

Patients, who have balances after insurance and require assistance in paying those bills, will be entitled to a Charity Care Patient Assistance discount, based on their income and family size, using the approved sliding financial assistance scale. The state of Connecticut has set recommended levels of charity care discounts which stipulates that for families at or below 200% of federal poverty levels should be discounted to cost and that for families between 200% and 400% should be discounted to the commercial and or Medicare rate. BHHCG sliding scale will have greater discounts applied at lower levels of the Federal Poverty Income Levels.

**Requirements**

**For Charity Care Uninsured Discount:** Only requirement is that they have no access to insurance. The discount will be immediate and applied to all uninsured patients.

**For Charity Care Patient Assistance:** To qualify, the patient or family must owe a balance to the hospital after insurance. They must request assistance in paying their balance. They must submit their most recent pay stub and declare the number of family members living in their household.

**Notification:** We will post a notice of our financial assistance policy at all registration points and other visible locations throughout the hospital. We will also print a notice on all bills and statements informing patients and families to call us if the need financial assistance.

**Published Statements:** The following statement will be posted at all registration areas, in a highly visible manner, and be posted on all patient statements and bills. The statement will be published in English and Spanish.

"Bristol Hospital provides financial assistance to patients who are uninsured or need assistance in paying their balances after their insurance has paid. If you have no insurance, Bristol Hospital will apply an **"Uninsured Discount"** to your bill down to what the Hospital gets paid by Medicare, on an average basis.

If after that **"Uninsured Discount"** the patient still has difficulty in paying the bill, the patient may apply for a **"Patient Assistance Discount"**. That discount is based on household income and family size. A sliding scale will determine the ultimate discount based on those factors. Please provide the most recent pay stub and declare the number of family members in the household.

If the Patient needs assistance in paying their balances after their insurance has paid, for coinsurances, co-pays or deductibles, the patient may apply for a **"Patient Assistance Discount"**. That discount is based on household income and family size. A sliding scale will determine the ultimate discount based on those factors. Please provide the most recent pay stub and declare the number of family members in the household.

To apply for the **"Uninsured Discount"** or **"Patient Assistance Discount"**, please call **860-585-3035** to speak with the Financial Counselor or visit **Bristol Hospital's Brewster Rd. Bristol, Connecticut 06010 Level C.**

## **REDUCED FEES APPLICATION PROCESS**

### **PLEASE READ THIS CAREFULLY**

Attached please find the Reduced Fees application.

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

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

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



**BRISTOL HOSPITAL, INC.  
REDUCED FEE  
ELIGIBILITY DETERMINATION**

Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Account Number(s): \_\_\_\_\_

Dear Client:

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

Date Completed Application Received: \_\_\_\_\_

Date Application Processed: \_\_\_\_\_

\_\_\_\_\_ Approved: Reduction Rate \_\_\_\_\_ % of services not covered by insurance.

Your new balance is \$ \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Denied: Reason For Denial \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ 860 585 3035  
Coordinator, Financial Assistance

\_\_\_\_\_ Maria Simmohe Director Revenue Cycle

\_\_\_\_\_ Chief Financial Officer



### STATEMENT OF COLLECTION POLICY

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

Reviewed: Oct 2014

<input checked="" type="checkbox"/> BH-HOSPITAL, INC. BOX 877 BRISTOL, CT 06011-0877 Department #14	<b>POLICY NO: 06012011-001</b>
<b>Title: POLICY PROCEDURE</b>  <b>CREDIT COLLECTION</b>	Approved by: <b>Revenue Cycle Director</b> <b>Maria Simone</b> Date approved: <b>6/1/2011</b> Date Reviewed: <b>5/1/2011</b> Date Revised: <b>2/1/2013</b>
<b>Applies to: CREDIT COLLECTORS</b>  Department(s) <b>BH Business Office</b> Reports to: <b>Patient Receivables Manager</b>	

**PURPOSE:**

To provide BH patient medical claim balances payment recovery, (Cardon Health) (VIA Healthcare) Credit Collection (American Adj and Medconn).

**POLICY STATEMENT:**

It is our policy to provide the highest quality of collection services to our patients for services provided to them by Bristol Hospital.

**SCOPE OF AUTHORITY / COMPETENCE**

Patient Receivables Manager, Revenue Cycle Director

**CREDIT COLLECTION PROCEDURE**

To provide direction to the business office staff and to ensure consistency of approach for the following parameters that have been established through-out the Business Office.

- I. All Uninsured patient claims over \$1000.00 are automatically transferred to Cardon Health upon discharge. Cardon Health contacts the patient and assists them with the State Assistance enrollment process. Patient accounts that do not qualify for assistance are returned weekly via email to the Pt. Receivables Manager. Agency codes are changed from Cardon Healthcare to VIA Health. Accounts are then sent to VIA Health electronically. VIA will produce patient statements, payment arrangements and Final Notice Letters. No less than two (30 day) statements and Final Notice Letter are mailed to the patients unless "Insufficient Addresses" are found. If there has been no payments and/or missed payments, VIA will close the claim and return to the business office electronically via email to the Pt. Receivables Manager. The Credit Collection collector will then place accounts with BH outside collection agency.
- II. Effective 2/1/2013, 100% of Bad Debt Collection claims will be submitted to American Adjustment Bureau.

**FOLLOW-UP PROCEDURE**

To provide direction to the Credit Collection staff that are responsible for Bankruptcy Notices, Auto claims, Liability claims and Attorney requests. Ensuring all patient claims are handled timely and correctly while following all HIPPA

requirements and those patients are billed appropriately for responsible balances

- I. Pending/Discharge of Debtor Bankruptcy notices are documented in Meditech and copies are sent to the Collection Agency, copy of the claim is printed and forwarded with the notice to the Pt. Receivables Manager.  
for the Uncollectable W/O.
- II. Attorney, Auto and Liability claim requests are reviewed to ensure there is a "Pt Authorization" letter signed and dated on file. If approved submit information and forward requests to other departments if necessary.

CREDIT COLLECTION - *Screens*

Detailed Follow-up Procedure

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

TIME FRAME:                      ACTION                      RESPONSIBILITY

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

Receipt of report from Data to Credit Rep                      CREDIT REP.

*Credit Rep researches each account via the system using:*

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

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

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

*Final Notices are produced by the 18<sup>th</sup> of the month.*                      DATA

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

*End of Month W/O to Bad Debt*

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

Revised: 10/02/2002

*Rev. 3-4 Mad*

*Rev. 2-8 Mad*

*Reviewed 10-11 Mad*

*Rev 10-12 MAL*



SAINT FRANCIS Care Partner

P.O. Box 977  
Bristol, CT 06011-0977  
860-585-3000

<http://www.bristolhospital.org>

## PAYMENT PLAN PROCEDURES

EFFECTIVE 6/1/2011, PATIENT PAYMENT PLANS ARE NORMALLY HANDLED BY VIA HEALTHCARE. PATIENTS SHOULD CONTACT VIA TO DISCUSS PAYMENT ARRANGEMENTS BY CALLING, 860 585 3691.

ANY PATIENT THAT IS REQUESTING A PAYMENT PLAN BY BRISTOL HOSPITAL MUST FOLLOW OUR POLICY OF 3 MONTHLY PAYMENTS PER INDIVIDUAL ACCOUNTS WITH THE CLAIM BEING PAID IN FULL ON THE LAST MONTH.

VIA HEALTHCARE WILL RECEIVE AND HANDLE ALL PAYMENT PLAN ACCOUNTS WITH THE PATIENT AND MONITOR ALL PAYMENT ARRANGEMENTS. ANY PAYMENT ARRANGEMENT IS CONTINGENT ON PAYMENTS BEING RECEIVED TIMELY PER THE AGREEMENT.

EFFECTIVE:6/1/2011

Rev. 10/12 Mal  
1/14 MAL

Rev. 10.1.14 Mal

## POLICY AND PROCEDURES

### COLLECTION AGENCY EXHAUSTED EFFORT ACCOUNTS

- #1 THE COLLECTION AGENCY CLOSES AND RETURNS ACCOUNTS QUARTERLY TO BH AS "UNCOLLECTABLE".
- #2 THE REPORT CONSIST OF THE FOLLOWING INFORMATION:  
PT ACCOUNT NUMBER, PT NAME, DOS AND CURRENT TOTAL BALANCE OWED. REPORTS ARE EMAILED ENCRYPTED TO THE PATIENT RECEIVABLE MANAGER.
- #3 THE CREDIT COLLECTION SPECIALIST UPDATES MEDITECH AGENCY CODE TO "EXHAUSTED EFFORTS".  
MCCA EXH EFFORTS  
AAB EXH EFFORTS
- #4 ALL "EXHAUSTED EFFORTS" ACCOUNTS WILL REMAIN ON MEDITECH AND NOT BE PURGED. NO FURTHER COLLECTION ACTION WILL BE HANDLED AT THIS POINT.
- #5 ANY PAYMENTS THAT MAY BE RECOVERED ON EXHAUSTED EFFORT ACCOUNTS WILL BE POSTED ON THE ACCOUNT WITHOUT ANY COMMISSION BEING SENT TO THE AGENCIES.

EFFECTIVE 6/1/2011

Reviewed by: ML 10/1/2012

Rev. 10.1.14 Mad



a SAINT FRANCIS Care Partner

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**COLLECTION AGENCY EXHAUSTED EFFORTS  
POLICY AND PROCEDURES  
MEDITECH SYSTEM**

- #1 COLLECTION AGENCIES RETURN ACCOUNTS BACK TO BRISTOL HOSPITAL THAT THEY CONSIDER ARE NO LONGER COLLECTABLE.
- #2 LISTED OF PATIENTS REFLECTING ACCOUNT NUMBER, PT NAME, DOS AND TOTAL AMOUNT OUTSTANDING ARE EMAILED FROM THE AGENCY ENCRYPTED TO BH PATIENT RECEIVABLE MANAGER.
- #3 THE EMAIL IS THEN HANDLED BY THE BH CREDIT COLLECTION REP WHO CHANGES THE COLLECTION AGENCY CODE TO THE EXHAUSTED COLLECTION AGENCY CODE IN MEDITECH SYSTEM.
- #4 ACCOUNT REMAIN MEDITECH AND DO NOT GET PURGED BUT ARE NOT WORKED AFTER THIS POINT.
- #5 ANY PAYMENTS THAT POSSIBLE ARE RECOVERED ON EXHAUSTED EFFORT ACCOUNTS IS POSTED ON THE ACCOUNT WITHOUT ANY COMMISSION BEING SENT TO THE AGENCIES.

EFFECTIVE 6/1/2011

Rev 10/12 MAL

Rev. 10.1.14 Mad

## SMALL BALANCE W/O PROCEDURE

*Series*

THIS PROCEDURE IS USED TO AUTOMATICLY SELECT SMALL BALANCES THAT ARE \$9.99 AND UNDER FROM THE ACTIVE A/R. *FOLLOW THE STEPS BELOW UNDER HOSPITAL I, II AND III.*

**\*\*PLEASE NOTE SMALL BALANCE CREDITS WILL NOT APPEAR ON THIS SMALL BALANCE W/O LIST. ALL CREDITS ARE FOLLOWED- ON UP BY THE ACCOUNT RECEIVABLE DEPARTMENT.**

1. OPTION 21 TO CLEAR OUT FILE      CB/DSBWF  
ENTER OPTION #1 (SM BALANCE W/O FILE)  
AND ENTER
  
2. OPTION 16 (PENDING SM BAL. W/O LIST  
DATE STAYS TO TODAYS DATE  
PRINTER NAME:      QPRINT  
CALL I.S. TO PRINT REPORT
  
3. OPTION 19 (UPDATE SM BAL. W/O LIST  
CALL I.S TO PRINT UPDATED REPORT AND SAVE  
TO LASER VAULT.

EFFECTIVE: 9/18/1997

Lin Pierce

*Rev. Mat 3.4*

*Rev 2.8 Mat*

*Rev. 9-1-11 Mat*

*Rev 10/12 Mat*

*Rev. 10-1-14 Mat*



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### **SMALL BALANCE W/O PROCEDURE MEDITECH**

**This procedure uses an automatic selection and write off for balances \$9.99 and under from the active Account Receivable.**

**There is a report that reflects all Small Balance write offs under the "Process Batches" in B/AR Meditech.**

**Effective 6/1/2011**

**REV: 10/1/2014**

## W/O OR REINSTATEMENT FROM B/D PROCEDURE

*Series*

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

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

The following screen will appear.

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

*Rev. 3.4 Mar*

*Rev 2.8 Mar*

*Reviewed 1-1-12 Mal*

*Rev 10/12 MAL*

*Rev. 10-1-14 Mal*

UNCOLLECTABLE W/O PROCEDURES

*Series*

ITEMS THAT MAY FALL UNDER WRITE OFFS:

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

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

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

PT RECEIVABLE MANAGER: MARYLOU HORVATH

*Jennifer Salomone*

*Rev Cycle Dir. Maria Turinone*

REVIEWED 2/05 03

*SERIES Rev. 9.1.11 Mad*

*Rev 10/12 M & L*

*Rev. 10.1.14 Mad*

## UNCOLLECTABLE W/O PROCEDURES

BEFORE MONTH END ANY ACCOUNTS THAT QUALIFY FOR WRITE OFF IS SUBMITTED TO THE PATIENT RECEIVABLE MANAGER FOR APPROVAL. THE ACCOUNT IS THEN, SUBMITTED TO THE VP OF IM FOR HER APPROVAL. IF THE ACCOUNT IS \$5000.00 OR HIGHER IT ALSO MUST BE SIGNED BY BH CFO BEFORE THE ACCOUNT MAY BE WRITTEN OFF AS UNCOLLECTABLE. THERE MUST BE DOCUMENTATION SUPPORTING THE REASON FOR THE WRITE OFF AND DOCUMENTED IN THE SYSTEM.

ONCE THE ACCOUNT HAS BEEN APPROVED FOR THE WRITE OFF THEN THE ACCOUNT WILL BE ADJUSTED TO ZERO. COPIES OF ALL WRITE OFFS ARE FILED AND SAVED FOR FUTURE AUDIT NEEDS.

REVIEWED: MARYLOU L'ETOILE 1/2011

DIRECTOR OF REVENUE CYCLE: MARIE SIMMONE

REVIEWED 12/2011

*Mad*  
*Rev 10-12 MAL*  
*Rev. 10-1-14 Mad*



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**MONTH END UNCOLLECTABLE W/O  
MEDITECH**

**ALL UNCOLLECTABLE ACCOUNTS \$5000 OR OVER MUST BE REVIEWED BY THE CFO FOR APPROVAL, SIGNED AND DATED BEFORE THE ACCOUNT BALANCE IS WRITTEN OFF.**

**ANY UNCOLLECTABLE PROVIDER LIABLE ACCOUNTS UNDER \$5000 MUST BE APPROVED, SIGNED AND DATED BY THE DIRECTOR OF PATIENT ACCOUNTS.**

**ONCE THE ACCOUNTS HAVE BEEN APPROVED THEY ARE THEN PASSED TO THE ACCOUNTS RECEIVABLE STAFF TO ENTER ON MEDITECH THE ADJ/P/L.**

**BACK UP IS SAVED WITHIN THE BUSINESS OFFICE ON ALL DOCUMENTS.**

**ALL PROVIDER LIABLES ARE WRITTEN OFF AT MONTH END.**

**EFFECTIVE 6/1/2011  
REV: 10/1/2014**

## MEDICARE BAD DEBT

### PROCEDURE- PART I SERIES & MEDITECH

It is the responsibility of the Patient Receivable Manager to complete the online Medicare Bad Debt Excel Exhausted Collection Returns for Medicare Self-Pay Patient balances returned by the collection agencies and Medicare Secondary State Co-Ins/Deductible unpaid balances. The required information for the Medicare Bad Debt spreadsheet is as follows:

#### INFORMATION:

1. PT NAME
2. PT MEDICARE ID #
3. PT ADMIT/DISC DATE
4. PT STATE ID #
5. DATE FIRST BILLED TO PT
- 6A. WRITE OFF DATE FROM B/D

#### MEDITECH/ B/AR/ PROC ACCT SERIES FUNCTION

- 6B. WRITE OFF DATE (state)
7. REMITTANCE ADVICE DATE
8. DED/CO-PAY

ARI (Accounts Rec. Inquiry)  
IBM (Ins. Benefits Maint.)  
ARI  
IBM  
CNI (COLLECTION NOTE INQ)  
LETTER DATE ON RETURNED  
ACCTS FROM AGENCIES  
NEVER LESS THEN 120 DAYS  
  
ARI (DATE OF STATE CROSS-  
OVER ADJ.)  
ARI (DATE OF THE  
MEDICARE PAYMENT)  
CNI (POSTED FROM  
MEDICARE REMITTANCES

Medicare Bad Debt Logs are submitted yearly to the Reimbursement Dept. for Cost Reporting.

#### OTHER FACTS:

- Only accounts with verified back up are to be reported on the log.
- Excel spreadsheets must be in format required by CMS.
- All logs must have a total line on each page for total Ded/Co-Pay amounts.
- All In-Pt, Out-Pt, State Ded/Co-Pay balances and Collection Agency returns are on separate Excel spreadsheets.
- All logs are emailed and printed and a copies maintained by the Pt. Receivable Mng.
- No part B charges are reported.
- Any accounts that have had payments refunded, recouped or late charges after initial billing will not be reported.

- Once accounts have been reported on the Excel Spreadsheet, the Agency Code is changed to "19" Medicare/Exhausted Efforts" in ARPT (ACCTS REC INQUIRY in Series- At END OF MONTH, Update Write Off From Bad Debt is completed by Pt Rec Manger. This purges the account balance from our Series System.

REVISED - JAN 1995

REVIEWED JAN 2004

REVIEWED JAN 2006

REVIEWED JAN 2008

REVIEWED & REVISED FOR MEDITECH JAN 2011

*Rev. 10.1.14 Mad*

**BRISTOL HOSPITAL, INC. BREWSTER RD. BRISTOL CT 06010**

**MEDICARE BAD DEBT MORTATORIUM AND CLARIFICATION  
OF BAD DEBT POLICY**

**DATE: 3/9/07**

**TO: MEDICARE PART A PROVIDER AUDIT**

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

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

*Rev 2.8 Mad*  
*Reviewed 12.10 Mad*  
*Reviewed 10-1-11 Mad*  
*Rev. 10-1-14 Mad*

**§413.178**

**42 CFR Ch. IV (10-1-04 Edition)**

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

**§413.178 Bad debts.**

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

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

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

**§413.180 Procedures for requesting exceptions to payment rates.**

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

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

(c) *Application of deductible and coinsurance.* The higher payment rate is

subject to the application of deductible and coinsurance in accordance with §413.176.

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

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

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

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

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

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

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

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

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

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

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

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