

**Bristol Hospital**  
**Fee Schedule as of 2/3/09**  
**@ 1 Times Poverty Guidelines**

For family size over 8 add: **\$3,740**

Annual Gross Family Income		Weekly Gross Family Income		Percentage of Free Care
From	To	From	To	

**Family Size**

<b>1</b>	\$0	\$10,829	\$0	\$208	100%
	\$10,830	\$12,032	\$209	\$231	90%
	\$12,033	\$13,236	\$232	\$255	80%
	\$13,237	\$14,439	\$256	\$278	70%
	\$14,440	\$15,642	\$279	\$301	60%
	\$15,643	\$16,846	\$302	\$324	50%
	\$16,847	\$18,049	\$325	\$347	40%
	\$18,050	\$19,252	\$348	\$370	30%
	\$19,253	\$20,456	\$371	\$393	20%
	\$20,457	\$21,660	\$394	\$417	10%
<b>2</b>	\$0	\$14,569	\$0	\$280	100%
	\$14,570	\$16,188	\$281	\$311	90%
	\$16,189	\$17,807	\$312	\$342	80%
	\$17,808	\$19,426	\$343	\$374	70%
	\$19,427	\$21,045	\$375	\$405	60%
	\$21,046	\$22,663	\$406	\$436	50%
	\$22,664	\$24,282	\$437	\$467	40%
	\$24,283	\$25,901	\$468	\$498	30%
	\$25,902	\$27,520	\$499	\$529	20%
	\$27,521	\$29,140	\$530	\$560	10%
<b>3</b>	\$0	\$18,309	\$0	\$352	100%
	\$18,310	\$20,343	\$353	\$391	90%
	\$20,344	\$22,378	\$392	\$430	80%
	\$22,379	\$24,412	\$431	\$469	70%
	\$24,413	\$26,447	\$470	\$509	60%
	\$26,448	\$28,481	\$510	\$548	50%
	\$28,482	\$30,516	\$549	\$587	40%
	\$30,517	\$32,550	\$588	\$626	30%
	\$32,551	\$34,585	\$627	\$665	20%
	\$34,586	\$36,620	\$666	\$704	10%

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	From	To	From	To	
4	\$0	\$22,049	\$0	\$424	100%
	\$22,050	\$24,499	\$425	\$471	90%
	\$24,499	\$26,949	\$472	\$518	80%
	\$26,949	\$29,399	\$519	\$565	70%
	\$29,399	\$31,849	\$566	\$612	60%
	\$31,849	\$34,299	\$613	\$660	50%
	\$34,299	\$36,749	\$661	\$707	40%
	\$36,749	\$39,199	\$708	\$754	30%
	\$39,199	\$41,649	\$755	\$801	20%
	\$41,649	\$44,100	\$802	\$848	10%
5	\$0	\$25,789	\$0	\$496	100%
	\$25,790	\$28,655	\$497	\$551	90%
	\$28,656	\$31,520	\$552	\$606	80%
	\$31,521	\$34,386	\$607	\$661	70%
	\$34,387	\$37,251	\$662	\$716	60%
	\$37,252	\$40,117	\$717	\$771	50%
	\$40,118	\$42,982	\$772	\$827	40%
	\$42,983	\$45,848	\$828	\$882	30%
	\$45,849	\$48,713	\$883	\$937	20%
	\$48,714	\$51,580	\$938	\$992	10%
6	\$0	\$29,529	\$0	\$568	100%
	\$29,530	\$32,810	\$569	\$631	90%
	\$32,811	\$36,091	\$632	\$694	80%
	\$36,092	\$39,372	\$695	\$757	70%
	\$39,373	\$42,653	\$758	\$820	60%
	\$42,654	\$45,935	\$821	\$883	50%
	\$45,936	\$49,216	\$884	\$946	40%
	\$49,217	\$52,497	\$947	\$1,010	30%
	\$52,498	\$55,778	\$1,011	\$1,073	20%
	\$55,779	\$59,060	\$1,074	\$1,136	10%

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Annual Gross Family Income		Weekly Gross Family Income		Percentage of Free Care
From	To	From	To	

7	\$0	\$33,269	\$0	\$640	100%
	\$33,270	\$36,966	\$641	\$711	90%
	\$36,967	\$40,662	\$712	\$782	80%
	\$40,663	\$44,359	\$783	\$853	70%
	\$44,360	\$48,056	\$854	\$924	60%
	\$48,057	\$51,752	\$925	\$995	50%
	\$51,753	\$55,449	\$996	\$1,066	40%
	\$55,450	\$59,146	\$1,067	\$1,137	30%
	\$59,147	\$62,842	\$1,138	\$1,209	20%
	\$62,843	\$66,540	\$1,210	\$1,280	10%
8	\$0	\$37,009	\$0	\$712	100%
	\$37,010	\$41,121	\$713	\$791	90%
	\$41,122	\$45,233	\$792	\$870	80%
	\$45,234	\$49,346	\$871	\$949	70%
	\$49,347	\$53,458	\$950	\$1,028	60%
	\$53,459	\$57,570	\$1,029	\$1,107	50%
	\$57,571	\$61,682	\$1,108	\$1,186	40%
	\$61,683	\$65,795	\$1,187	\$1,265	30%
	\$65,796	\$69,907	\$1,266	\$1,344	20%
	\$69,908	\$74,020	\$1,345	\$1,423	10%

### **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 an outside collection agency. Collection action will be taken by the agency, on behalf of the Hospital, to secure payment, not excluding legal action when appropriate.

## **COLLECTION POLICY AND PROCEDURE**

**TO: BILLING OFFICE STAFF**

**RE: REQUESTED INFORMATION RECEIVED FROM INSURANCE CARRIERS  
FOR INFORMATION NEEDED DIRECTLY NEEDED FROM THE  
INSURED.**

**WHEN BILLERS RECEIVE NOTICE FROM INSURANCE COMPANIES THAT  
THE ACCOUNT WILL BE PENDING DUE TO MISSING OR NEEDED  
INFORMATION DIRECTLY FROM THE INSURED PARTY, THE BILLER WILL  
DOCUMENT THIS IN CNI AND A COPY OF THIS INFORMATION WILL BE  
SUBMITTED TO THE COLLECTION RECEIVABLE MANAGER.**

**THE COLLECTION RECEIVABLE MANAGER IS RESPONSIBLE FOR  
CONTACTING THE INSURED BY TELEPHONE TO INFORM THE INSURED  
THAT THEY MUST CONTACT THEIR INSURANCE COMPANY.**

**PLEASE NOTE THIS DOES NOT INCLUDE THE AUTO AND LIABILITY CLAIMS  
THAT ARE SUBMITTED BY THE BILLERS DIRECTLY TO OUR COLLECTOR  
ESTHER HEBERLE FOR FOLLOW-UP.**

**EFFECTIVE: MARCH 23, 2007**

*Rev. 10-15-09* ✓

# CREDIT COLLECTION

## 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 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.

CREDIT REP.

*Removing accounts not being sent a Final Letter*

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

CREDIT REP.

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

- 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.

DATA

*End of Month W/O to Bad Debt*

- a. All accounts that received a Final Notice Letter are 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.

CREDIT MNG

Revised: 10/02/2002

Rev. 3.4 Mark

Rev. 2.8 Mark

Rev 2.9 Mark

## PATIENT PAYMENT PLAN PROCEDURE

When a Guarantor/Patient requests a monthly Payment Plan on their open balance accounts the following procedure will be followed.

- a. Payment Plan is set up so the balance owed will be paid within least amount of time. Credit Collection Rep will have the Guarantor/Patient complete a Payment Plan form and a copy of the form is saved in the In-Pt Collector's office.
- b. A revised Payment Plan will need to be setup with the Guarantor/Patient if there is still outstanding accounts or new accounts unpaid from one year of the original Payment Plan.
- c. Payment Plans will be voided if payments are not received timely.
- d. Payment Plans may not be less than \$35.00 monthly without the Pt Directors signature.

### *Procedure for Payment Plans*

- a.. CNI- each account listed under the Payment Plan agreement will be documented in Collection Note Inquiry by the Credit Rep.
- e. Under Collection Menu (BHCM) the payment plan will be entered.(PPM)
- f. If there is a broken Payment Plan, Credit Rep will delete the Payment Plan and inform the Guarantor/Patient (PPM). This action will remove the Payment Plan from the monthly statement to the Guarantor/Patient.

Revised: 10/02/2002

Rev. 3-4 Mad

Rev 2-8 Mad

Rev 2-18-9 Mad

## COLLECTION AGENCY PLACEMENT PROCEDURE POLICY

Perform Collection Agency Placement Procedure for agencies as follows:  
10% of total amount placed is sent to American Adjustment Bureau only.  
90% of Collection Placement is sent to Medconn Collection Agency.

### HOSP I

UNDER BH CUSTOM WRITE OFF MENU (UMENUWO) SELECT #40(MEDCONN CREATE DISKETTE) AND #41(BH CREATE AMERICAN ADJ DISKETTE) ENTER WRITE OFF TO BAD DEBT DATE AND ENTER. CALL I.S. (INFORMATION SERVICES) TO PRINT LAST PAGE OF REPORT X2 AND DISKETTS) (DATE THAT IS ENTERED IS THE DATE OF THE END OF THE MONTH CLOSING) - *Sent electronically to agencies*

### HOSP II

SAME PROCEDURE AS HOSP I LISTED ABOVE BUT ONLY #40 (MEDCONN CREATE DISKETTE) IS REQUESTED.

Last page of Write to BD is sent to the agencies <sup>*electronically*</sup> ~~with diskette~~. Pt Receivable Mng enters the total accounts and dollars into an excel spreadsheet names FACCTSPL4 (number changes each new Fiscal Yr)

At the end of the Fiscal Year, the excel FACCTSPL sheet is emailed to the hospital control officer.

This procedure is performed during the end of the first week of each month.

Reviewed Dec 2007  
Marylou Horvath

*Rev. 12.08*

*Rev. 12-16-09 [Signature]*

**COLLECTION EXHAUSTED EFFORTS**

**POLICY AND PROCEDURES**

**STEP:**

1. **COLLECTION AGENCY WILL RETURN ACCOUNTS TO HOSPITAL QUATERLY THAT ARE NO LONGER COLLECTABLE.**
2. **IN HOSPIAL SYSTEM UNDER A/R PAYOR TRANSFER (ARPT) CHANGE COLLECTION AGENCY CODE TO EITHER (20) OR (19) MEDICARE ACCOUNTS WITH PT CO PAY/DED ONLY.**
3. **BEFORE COMPLETING W/O FROM BAD DEBT FUNCTION RUN OPTION 11 W/O FROM BAD DEBT SELECTION (W/OFBDS) FOR REIMBURSEMENT REPORT TO MEDICARE ON ONLY AGENCY (19).**
3. **TO REMOVE FROM BAD DEBT FILE TAKE OPTION 14 (UW/OFBDD) \*\*\*\*CHOOSE ONLY EITHER AGENCY CODE 19 AND/OR 20\*\*\*. NEVER LEAVE BLANK OR ENTER ANY OTHER AGENCY CODE OR BALANCES WILL BE PURGED FROM BAD DEBT FILE.**
4. **ANY RECOVERIES ON PURGED BAD DEBT ACCOUNTS ARE EITHER REINSTATED UNDER (RAA) FUNCTION OR PLACED IN "RECOVERY TO BAD/DEBT "BY ACCOUNTS RECEIVABLE DEPARTMENT.**
5. **OTHER REASONS FOR W/O BAD DEBT ACCOUNTS ARE AS FOLLOWS: BANKRUPTCY ACCOUNTS, NO ESTATE, BRISTOL HOSPITAL SETTLEMENTS (ONLY WITH DIRECTORS APPROVAL)**

Reveiwed Mar 04

Rev 2.08  
Rev 2009 *Mad*

## SMALL BALANCE W/O PROCEDURE

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 2-09 Mat

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

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 Reinstatement 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 Mah

Rev 2.8 Mah

Rev 12.08 Mad

## UNCOLLECTABLE W/O PROCEDURES

### 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*  
*Res Cycle Dir. Maria Salomone*

REVIEWED 2/08

*Res 2-09 M. Betoile*

5. W/O To Bad Debt Maintenance	WOBDM
6. List Pending W/O To Bad Debt	LPWOBD
7. Update W/O To Bad Debt	UWOBD
9. Pending B/D W/O Ageing Report	PBDWOAR
11. W/O From Bad Debt Selection	W/OFBDS
12. W/O From Bad Debt Maintenance	WOFBDM
13. List Pending W/O From Bad Debt	LPW/OFBD
14. Update W/O From Bad Debt	UW/OFBD
16. Small Balance W/O Selection	SBWOS
17. Cancel Small Balance W/O	CSEWO
18. List Pending Small Bal. W/O	LPSBWO
19. Update Small Balance W/O	USBWO

**Key in a Function #/Mnemonic:** .....

**Security Code:**

PgUp/PgDn

F1=Help

F2=Clear Sec

F3=Exit

F4=Prompt

F9=Retrieve

F13=Disp Msg

F14=Send Msg

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.**

*Rw 2-8 Mad*

*Rw 2-9 Mad*



400 South Salina Street  
Syracuse, New York 13202  
www.NGSMedicare.com

A CMS Contracted Agent

# Medicare

888-855-4356

TO: All NGS Providers  
FROM: Medicare Part A, Provider Audit  
DATE: February 12, 2007  
SUBJECT: MEDICARE BAD DEBT MORATORIUM & CLARIFICATION OF BAD DEBT POLICY

National Government Services (NGS), formerly Empire Medicare Services (EMS), wants to re-emphasize certain information concerning reimbursement for Medicare bad debt expense. CMS has provided FI's (Fiscal Intermediaries) clarification on the application of the "bad debt moratorium" that was promulgated by the Omnibus Budget Reconciliation Act of 1987. The moratorium relates to bad debts that are referred to a collection agency after the provider has documented the required prompt and continuous internal collection effort for at least 120 days (refer to the PRM Section 310.2). The moratorium prohibits FI's from disallowing bad debt expense for the sole reason that the related bad debt was referred to a collection agency after the required prompt and continuous internal collection effort was documented, if the FI's policy on August 1, 1987, had been to allow these amounts.

However, since NGS did not review bad debts in each year since 1987, we are not in possession of the provider's billing and collection and write-off policies. As such, the provider will need to demonstrate that it continues to meet the moratorium. Please be advised that an attestation from a provider will not meet the documentation requirements in reference to their policy being unchanged from 1987. The moratorium will not continue to apply if any of the following situations have occurred subsequent to August 1, 1987:

- The provider has changed the collection policy.
- The provider transferred to/from another fiscal intermediary (NGS from EMS switch not considered).



- The provider has undergone a change of provider type (ex. PPS Hospital to Critical Access Hospital)
- A change of ownership that resulted in a new provider number being issued.

In order for a provider to continue to be covered by the moratorium, the provider is required to provide documentation to the FI that the collection policy in effect on August 1, 1987, was explicitly approved by the FI and that the policy has not changed for the subsequent corresponding covered cost report periods. **Effective for cost report periods beginning on or after 6/30/07, providers will be required to submit this documentation to NGS for the moratorium to continue to be in effect.** That documentation should be made available at the time of the audit, when the NGS auditors ask for it. We are allowing approximately 5 months for providers to research this issue as it applies to any changes in the policy since 1987. Based on that information, NGS will work closely with providers to ensure the moratorium is applied timely and consistently and to answer any questions about this topic.

The Medicare instructions do not require a provider to utilize a collection agency, but do require that the account not be written off until it is deemed worthless and after 120 days of collection effort has been exhausted. However, if the provider continues to collect on an account, including referral to a collection agency, the debt is not considered worthless for Medicare reimbursement. In the absence of the moratorium, amounts sent to a collection agency as a continuance of the provider's collection effort must be documented/exhausted before it can be claimed in the cost report period. These amounts can only be claimed when the collection agency notifies the provider that the account is worthless and is then returned back to the provider. It would be at this is the time that the provider would write off the account from its account receivable system as a bad debt expense. The Medicare instructions require that the provider's policy for referral to a collection agency of similar dollar amounts must be the same for all payers. Therefore, we recommend (but cannot mandate) that the same write-off policy be established for non-Medicare accounts also. The provider may work with their collection agency to determine the timeframes when the agency should determine if the open balance is worthless and should be sent back to the provider. This policy may differ from past experiences.

As an additional point, please review your write-off policy to assure you restart the 120 clock whenever you receive full or partial payment for an unmet deductible and/or coinsurance amount. This is not a new policy but NGS wanted to advise providers that they should assure this is being done.

We wish to provide an opportunity for you to review your current practices and implement any necessary changes. We will inform you of any further developments on this issue. If you have questions concerning the bad debt moratorium or the related documentation requirements, please call your appropriate Audit Manager.

Sincerely,

*Steve Hartmann*

Steve Hartmann  
Director- Audit & Reimbursement Department  
National Government Services (formerly EMS)

CC: Peter Reisman- CMS- NY Regional office  
James Menza- CMS- Boston Regional office

**PROCEDURE**  
**MEDICARE BAD DEBT REPORT**

It is the responsibility of the Patient Accounts Manager to complete the online Medicare Bad Debt Log of exhausted Medicare accounts from collection. The required information for the Medicare Bad Debt Log is listed as follows:

- a. **PT NAME:** ARI (ACCTS RECEIVABLE INQUIRY)
- b. **PT MED. HIC #:** IBM (INS BENEFITS MAINT)
- c. **PT ADMIT/DISCH:** ARI (ACCTS RECEIVABLE INQUIRY)
- d. **PT WELFARE ID:** IBM (INS BENEFITS MAINT)
- e. **DATE FIRST BILL SENT TO BENEFICIARY CNI (COLLECT NOTE ENTRY)**
- f. **WRITE OFF FROM B/D DATE:** DATE LISTED ON COLLECTION AGENCY LIST WITH EXHAUSTED EFFORT PATIENT ACCOUNTS. \*\*\*ACCOUNTS ARE NEVER EXHAUSTED LESS THEN 120 DAYS FROM AGENCY RECEIVING THE CLAIM PER HOSPITAL CONTRACT WITH AGENCY.\*\*\*
- g. **REMITTANCE ADVICE DATE:** ARI (DATE ON THE ORIGINAL MEDICARE REMITTANCE WHICH IS ENTERED IN SERIES BY ACCOUNTS RECEIVABLE DEPT AT TIME OF POSTING MEDICARE REMIT)
- h. **DEDUCTIBLE/COPAY:** CNI (DED/COPAYS AMT INDICATED IN SERIES NOTE ENTRY AT TIME OF MEDICARE REMIT DOWNLOADING)

PAGE 2

**OTHER FACTS:**

Only accounts with verified back up are to be logged.

Excel log (exhibit 5) which is supplied by Medicare.

All logs are to have a total line on each page for total Co-pay/Ded amounts.

All In Patient, Out Patient, and Medicare and State patients are entered on separate logs.

All logs are forwarded by email to Bristol Hospital's, Reimbursement Department quarterly.

One hard copy is maintained by the Patient Receivable Manager.

No Part B charges are logged.

M.Horvath  
Pt. Receivable Manager

Effective August 1, 1987

Reviewed: Jan 1995

Reviewed: Mar 2004

Reveiwed: Mar 2007

Rev 12-1-08

### **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.

### All Payor General Billing Policy

- All patients are charged for services received according to the approved charge master of the Hospital.
- All charges are entered by the servicing department according to the patient account number.
- All claims are produced by the in-house computer system on the designated uniform bill UB92.
- All claims are billed to the responsible party or third party payor based on current requirement and within three (3) days of in-house generation.
- All patients are billed for balances appropriate according to Bristol Hospital policy and contractual agreements.

## **BRISTOL HOSPITAL REDUCED FEE POLICY**

### **STATEMENT OF POLICY**

Bristol Hospital will administer reduced fees in the minimum amount of \$500,000 per year to inpatients, ambulatory surgery patients, outpatient recurring services, single occurrence outpatient services with charges totaling \$500.00 or greater and Counseling Center clients, in accordance with its policy for insured balances, or any uninsured balances. Effective October 1, 1996, there will be no \$500.00 minimum required for uninsured patients.

### **GUIDELINES AND ALLOCATION PLAN**

Reduction will be determined on a first come first serve basis. 100% financial assistance will be provided to patients whose income is 100% 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. Exceptions will be considered based on individual circumstances and will require the review and approval of the Director of Patient Business Services.

Income will be evaluated on eight (8) consecutive weeks of gross earnings, verified by paycheck stubs, signed letter of income verification from the employer, official unemployment history report, notarized statements or federal income tax return if self-employed. Income will be calculated by totaling up the 8 consecutive weeks of gross earnings divide that number by 8, then multiply that number by 52 weeks. Income will be re-evaluated after four (4) weeks of any significant financial change for recurring services, as stated on the determination letter.

The family unit is defined as any single or married person eighteen years of age or older and spouse or live-in boyfriend/girlfriend and dependents or the parent/step parent or guardian of a patient under the age of eighteen, who resides in the same dwelling.

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 applied to each account balance.

All applicants are required to complete the application process according to Hospital policy. Each applicant completing the application process will receive a written letter of eligibility determination.

All appropriate account balances within the designated scope of services and within the applicant's guarantor account, at the time of determination will be considered for reduction. Accounts that may have other income adjustments will not be considered for reduction. All reductions will be applied to balances after insurance and all third-party-payor and/or administrators of other agencies have made appropriate payments and/or determinations.

Services included in this allocation plan are those designated in this statement of policy. All patients with services other than outpatient mental health and other recurring services will be required to reapply at each encounter. Approved reductions will be re-evaluated every six months for outpatient mental health patient and other recurring services. Any changes, including coverage issues, are the patient's responsibility. Any changes in past reductions will be calculated on balances owed at the time of re-application.

Referrals can be made by any Hospital employee who deals with patient financial matters. Patients will be referred directly to the Financial Assistance Department.

### **ADMINISTRATION AND RESPONSIBILITY**

It is the responsibility of the Financial Counselor to comply with the Hospital policy guidelines governing the distribution of Reduced Fee reductions.

The Financial Counselor is responsible for all application determinations and allowance procedures.

Allowances will be administered via monthly log and will be submitted timely to the Accounts Receivables Department Supervisor.

The Financial Counselor is responsible for all the record keeping including a written log of all allowances and pertinent information for audit purposes. Record keeping will include a copy of each application and determination letter and proof of adjustment application.

The Director of Patient Business Services will review and approve any requested exceptions in the administration of changes in the reduction process.

The accounting department is responsible for all calculations required by this policy including fee scales, reduced fee allocation amounts and the designated detail of procedure for such, the publication of information regarding these calculations to the public, and the monitoring and quarterly written communication of compliance standards to the appropriate persons and/or Agencies.

## **FREE BED FUND APPLICATION PROCESS**

### **PLEASE READ THIS CAREFULLY**

Attached please find the Free Bed Fund application.

If you feel you may be eligible according to these guidelines, 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.

- Last Income Tax Return Filed, if self-employed.
- 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.

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.

Date App. Sent: \_\_\_\_\_

**BRISTOL HOSPITAL, INCORPORATED**  
**APPLICATION FOR FREE BED FUND**

Date of Request: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Number and Street City State Zip

Social Security Number: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

Account #( 's) \_\_\_\_\_

List of Household Members and Their Relationship:

<u>Name</u>	<u>Relationship</u>	<u>Age</u>

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so that the hospital can judge my eligibility for free bed funds. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature: \_\_\_\_\_

The Financial Assistant Department will respond to your request within fifteen working days.

Approved: Reduction Rate: \_\_\_\_\_ % of service not covered by insurance  
Denied: \_\_\_\_\_

\_\_\_\_\_  
Coordinator, Financial Assistance Date \_\_\_\_\_

**BRISTOL HOSPITAL, INC.  
FREE BED FUND  
ELIGIBILITY DETERMINATION**

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

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

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

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

Dear Client:

Your application for free bed funds has been processed. Your eligibility has been determined as follows:

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

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

\_\_\_\_\_**Approved:** Reduction at \_\_\_\_\_ % of charges.

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

\_\_\_\_\_  
**Coordinator, Financial Assistance**

Cindy Beliveau  
Coordinator, Financial Assistance  
860-585-3878

**FREE BED FUNDS**  
**COLLECTION POLICY AND PROCEDURE**

PURPOSE: To process patient balances according to Section 19a-673 of the Ct. General Statues.

Patient accounts are considered **“uninsured”** as defined by the Ct. General Statues governing Free Care. The Guarantor will need to comply with the financial arrangements assigned by Bristol Hospital's Financial Assistance Department in order to be eligible for Free Bed Fund assistance.

The following sequence will apply:

1. A UB bill will be sent to the Guarantor at the time of billing and will include Bristol Hospital's Free Bed Information Form.
2. The Guarantor will continue to receive monthly statements (28 days apart) and follow regular collection policy and procedure until the Financial Department receives application from the guarantor. The Financial Assistance department will enter action code “LL” in the on line system to indicate the account is pending determination.
3. The Credit Department will bypass any further collection action on pending accounts and the account will remain in a “pending Free Bed” category until further notice.
4. If the account is approved for Free Bed Funds, the discounts and adjustments are entered on the log by the Financial Assistance Department and sent to the Pt. Receivable Manager for data input.

If the account is denied free Bed Funds due to failure to meet Bristol Hospital's guidelines, the account will be considered an “Insured Patient” and the Credit Department will follow the appropriate procedures for Insured Patients including sending the final notice of “insured” status on the unpaid balance.