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.

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

<table>
<thead>
<tr>
<th>UNINSURED PATIENT POLICY</th>
<th>SELF PAY DISCOUNT POLICY</th>
<th>CHARITY CARE POLICY</th>
</tr>
</thead>
</table>
| Patient has no insurance | Patient has no insurance | Balances in aggregate totaling <$1000 and are………
| Patient has been denied Medicaid/Saga | Patient’s income is above 200% poverty income guidelines | • Uncollectible Encounters
| Patient’s income is at or below 200% of the poverty income guidelines. If these 3 criteria apply, patient qualifies as uninsured and balance is reduced to zero. | Patient has a balance/s after insurance. *Aggregate Balance - <$200 - no discount applies |
|                           | *Aggregate balance – $201 to $999 - patient must complete a financial application for sliding scale discount or charity care. Presentation to PAC not required. |
|                           | *Aggregate balance - >$1000 – patient must complete a financial application for sliding scale discount. Case will be presented to PAC if patient is unable to comply with payment arrangements on balance after discount. |

Cost to Charge Alias – 2003 Refer to Cerner Free Bed transaction codes

Sliding Scale Alias – 2014 Prompt Pay Alias – 2013 Refer to Cerner Free Bed transaction codes

Charity Care Alias – 2010 Refer to Cerner Free Bed transaction codes
PATIENT ACCESS / FINANCIAL SERVICES

Credit and Collection Policies
Free Care Manual
Patient Statement Handbook

January 2008
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CREDIT & COLLECTION POLICIES

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OVERVIEW

The credit and collection policies cover many categories beginning with pre-admission and concluding with turnover to collection agencies. It is the intent of these policies to fully inform all patients, of the expectations of Waterbury Hospital for Encounter resolution. Waterbury Hospital will not deny necessary medical services due to insufficient financial resources, however, will inform and assist patients in pursuing financial assistance based on established regulations, criteria and available programs.

Policies governing certain aspects of Credit & Collection are also available in the Administrative Manual.
PATIENT ACCESS / FINANCIAL SERVICES DEPARTMENT SCOPE OF SERVICE

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

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

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

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

**Access Teams [Central Registration / ED Registration]**
- Scheduling
- Registration
- Insurance verification and validation
- Authorization
- Bed placement
- Cash collections.

**Customer Service**
- Walk-in patient/customer billing inquiries
- Telephone Unit – Incoming Encounter inquiries
Financial Counseling, Payment Arrangements
Patient Assistance case preparation and presentation.

Cash and allowance posting and reconciliation
Payment and allowance posting
Daily deposit
Remittance Uploading
Cashiering

Support Services
Electronic and hardcopy billing
Encounter analysis
Remittance analysis

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

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

HOURS OF OPERATION:
Emergency Department– 24 hours per day, seven days per week.
Central Scheduling/Registration – Monday through Friday, 6:00am – 6:00pm
Support Services – Monday through Friday, 8:00am – 4:30pm
Customer Service –Monday through Friday 8:00am – 4:30pm
Customer Service Phone Lines - Monday through Friday 8:30am - 3:30pm
OSI Outsourcing Phone Lines - Monday through Friday 8:00am – 5:00pm
WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES

ORGANIZATIONAL CHART FY08

Vice-President, Finance

Director, PAFS

PATIENT ACCOUNTS
- Asst Director, Patient Accounts
- Supervisor, Customer Service
- Supervisor, Cash Applications
- System Support
- Application Support
- Education / Training

CENTRAL REG/SCHEDULING
- Asst Director, Patient Access
- Manager, Central Reg/Sched
- Manager, ED Reg/Bed Control

TOTAL FTES – 59.9
SECTION I: CREDIT & COLLECTION POLICIES

**SCOPE:** To outline the processes associated with the reporting of Accounts Receivable for billed claims.

**PURPOSE:** To provide an outline of reports and software applications which are utilized for the analysis of Accounts Receivable.

**POLICY:**
It is the policy of Waterbury Hospital to regularly review the Accounts Receivable via various methods/processes, in order to insure the constant maintenance of billed AR for fiscal viability.

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

**PATIENT ACCOUNTING REPORTS**
A listing of these reports can be found in Explorermenu.exe.

**FINANCE REPORTS**
On a monthly basis, Finance provides an ageing report for AR and credit balances with delta change analysis.

**QMS**
The QMS software application provides a daily picture of the Accounts Receivable that can be reported in a variety of methods. The data is downloaded daily and is the most current AR data available for analysis.

**IMACS**
Imacs is a new application for the review of reimbursement according to contracted rates and is monitorer by the Finance Department.

As needed, payers and/or patient AR can be analyzed, reported and exported into Excel or Access, for further review.
WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES

<table>
<thead>
<tr>
<th>CATEGORY:  Credit and Collection Policies</th>
<th>POLICY:  ADR Policy</th>
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SCOPE:

PURPOSE: ADRs are requests for medical documentation for claim adjudication by Empire Medicare. Empire Medicare has set a specific timeline of 30 days for the processing of ADRs.

POLICY: It is the policy of Waterbury Hospital Support Services to efficiently disseminate ADRs [Empire Medicare Additional Development Requests] to hospital departments to insure timely follow-up back to Empire Medicare.

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

Procedure:
1. On a daily basis, support staff will query the FISS system for new ADRs. Some may be sent via mail. The forms are printed.
2. The ADR forms will be disseminated to the various departments for pulling of records.
3. The system will be documented that the ADRs have been sent to the appropriate departments.
4. The ADR with the medical documentation attached will be returned to Empire Medicare within the 30-day timeframe.
5. Behavioral Health will be responsible to document in the system that the documentation has been sent.
6. Other areas will be monitored by support services.
7. Encounters that pass beyond the 30 days in suspense are rejected by the Empire Medicare system and will need to be appealed.
**CATEGORY:** Credit and Collection Policies

**POLICY:** Audit Process for Medicare Bad Debt

<table>
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**SCOPE:**

**PURPOSE:** To provide an auditing process to insure that balances reported to Medicare as bad debts have been appropriately dunned according to Medicare guidelines.

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

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

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

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

PURPOSE: To insure that Encounters are appropriately flagged when bankruptcy is filed, and the appropriate forms are received and filed.

POLICY: To abide by the provisions of the Bankruptcy Law and cease all collection activity on Encounters when bankruptcy has been formally filed.

PROCEDURE:
The following guidelines apply when handling Encounters for patients who have filed bankruptcy:

NOTICE OF BANKRUPTCY
Upon receipt of bankruptcy notice, all encounters on or before the filing date are flagged with the Bankruptcy Indicator and all collection efforts are suspended. A copy is sent to our collection agencies.

The Encounters are documented that a bankruptcy notice was received, and there should be no patient contact at this time.

If a Proof of Claim is requested, the Cashier will forward any outstanding debts to the Bankruptcy court.

All Bankruptcy notices are filed and maintained by the Cashier.

DISCHARGE OF DEBT
Upon receipt of a discharge of debt notice, all open encounters with a date of service prior to the Bankruptcy discharge date, will be written off using the appropriate alias transaction code.

The Discharge of Debt is matched with the Bankruptcy Notice for record-keeping purposes and filed together.

Any Encounters that are granted a discharge of debt, and have been referred to a collection agency, are returned from collection to process the Bankruptcy adjustment.

BANKRUPTCY REPORT
The Bankruptcy Report should be checked at least quarterly to follow-up on cases where a discharge of bankruptcy has not yet been received.
**WATERBURY HOSPITAL**
**CREDIT & COLLECTION POLICIES**

<table>
<thead>
<tr>
<th>CATEGORY: Credit &amp; Collection Policies</th>
<th>POLICY: Commercial Audit Policy</th>
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</thead>
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<td>REVISED: 01/07, 12/07</td>
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**SCOPE:** Third-party payment audits  
**PURPOSE:** To allow auditors access to medical record charts and itemized bills for purposes of auditing; to resolve audit issues and provide education/information to affected departments

**POLICY:** It is the policy of Waterbury Hospital to work with Third-Party auditors as necessary to schedule, process and resolve chart/bill audits

**Procedure:**
 Audits will be scheduled with the Health Finance Department, in writing, by mailing/faxing/emailing an audit request containing, at a minimum, the following information:

- Patient Name
- Hospital Encounter Number
- Hospital Medical Record Number
- Admit Date
- Discharge Date
- Patient SSN
- Name of Insurance Carrier Requesting Audit
- Name of Audit Firm and Individual who will perform the Audit
- Reason Claim was Selected for Audit
- Balance Due

- The auditor will be required to present proper identification prior to commencing the Audit.

- Audits will be limited to verifying that the charges on the bill are correct and that the services ordered by the physician are accurate. The audit will not assess the medical necessity or the reasonableness of cost/charge pricing.

- Written authorization by the patient to release medical record information is required.

- Hospital Correspondence Copy Service will provide copies according to their payment schedule. [if copies are requested]

- Auditors should not expect to receive photocopied materials on the day of the audit.
WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES

A written report of the audit findings must be forwarded to the Manager, Revenue Compliance, within two weeks of the completion of the audit. The results will either be confirmed or contested by our audit agency within 30 days of the receipt of the report. The Waterbury Hospital reserves the right to submit additional documentation to resolve contested items within the 30 day span.

Monetary adjustments, when agreed upon, in writing by both parties, will be made to the insurance carrier or hospital within 30 days of such agreement.

Finance will maintain an audit log for statistical and internal audit purposes.
SCOPE: Credit Balances on AR encounters.

PURPOSE: To resolve credit balances in a timely manner.

**POLICY:** It is the responsibility of Patient Access/Financial Services to identify and process credit balances in a timely manner to patients and third-parties.

**GENERAL GUIDELINES:**

Credit balance report is produced monthly. The data is sorted by financial class, in descending dollar format.

Medicare has a separate report that follows federal guidelines.

Staff is expected to work credits every week. There is no "quota" at this time.

Credits are worked as follows:
- Each Encounter is reviewed to determine the cause of the credit balance
- Patient refund - if the patient has no other open Encounters, patient will be refunded.
- Insurance overpayment/error - insurance company will be refunded after remittance is pulled and reviewed.
- Allowance error - correction is made to resolve credit
- Refund forms are filled out and sent to Finance

Checks are returned to Patient Accounts for mailing.
CREDIT BALANCE / REFUND PROCESS

Self-Pay -
Check for other open Encounters
- If no other open Encounters, proceed with refund
- If there are other open Encounters, transfer credit

Insurance -
Pull remit, validate allowance and payment to insure accuracy of calculation and posting to the correct Encounter.
If correct, process refund
If not correct, transfer payment to correct Encounter

Special handling –
- State and City Welfare refunds are done on a payment appeal form. This form is sent to the state and the monies are recouped on future remits.
- Medicare A Empire Medicare refunds are resolved via adjusted or voided claims. Credit balances due to Medicare are reported on a quarterly basis utilizing specific filing instructions as per Medicare regulations. Any credit outstanding at the time of the quarterly credit report filing will be logged on that report.
- Medicare B First Coast is refunded via check and follows the insurance guidelines.
- Blue Cross is handled similarly with some exceptions [out of state, nationals, Blue Shield] which require refund checks.

Request refund form using letter functionality [this form must be used in place of an itemized bill]. Complete form in full.

Staple any remits to this form

Prepare an allowance sheet to reverse the amount of the refund being sent. Record the refund in the debit column of allowance sheet choosing he appropriate refund alias.

- Batch the refunds and put them in the refund bin for authorization.
- The batch should include the refund form with any attachments, the allowance sheet and a tape [double check the total]
- When the batch is returned, assign a batch number.
- The refund batch book is kept in the manager’s office. Log in the batch number, number of Encounters, dollar amount and initials.
- Document each Encounter in batch including the batch number.
- After all the above steps are completed, send the batch to Finance.
- Finance will process the refund within one week of receipt [dependent on cash budget available for refunding]
RETURNED REFUND CHECKS

Returned refund checks will be given to the appropriate manager and that person will be responsible for the investigation of the refund. If the refund has to be voided for any reason, special procedure codes must be used.

UNCLAIMED PROPERTY

Returned refund checks are investigated by the Assistant Director to determine the appropriate action needed to resolve the refund. If the refund check is returned for an invalid address, a search is done to obtain correct address. If an address is not available the check is turned over to the State of Ct as unclaimed property.

If the check is returned due to no forwarding address or patient deceased, the check is turned over to the State of Ct as unclaimed property.

To turn the check over to the state the following steps are taken.
A comment is written on the refund check explaining the reason why the check needs to be turned over to the state.
The manager dates and signs the comment.
The manager writes up two allowances. One allowance reverses the refund to create a credit on the Encounter. The second allowance debits the Encounter using the appropriate alias code for unclaimed property.
The refund check is then sent to the Finance department to forward on to the state.

Small credit balances 5.99 and under are written off automatically to unclaimed property on a monthly basis.

MEDICARE PART A - EMPIRE BLUE CROSS REFUND PROCESS

A special credit balance report is generated on a quarterly basis for any Encounter with a Medicare health plan listed. Each Encounter is reviewed to determine if Medicare is entitled to any monies. If Medicare is due a refund, an adjusted UB92 is faxed to Medicare for payment retraction. Once processed by Medicare, the retraction will appear on a remittance advice and the allowance will be reversed at time of posting.

QUARTERLY REPORT

Medicare regulations require a quarterly credit report. [Hard copy and disk]. This report is for any Encounters not captured by the above process. The report is divided by inpatient and outpatient Encounter status.

A UB92 and Medicare remit for each Encounter must be submitted along with the quarterly report. A duplicate set is kept by Patient Access/Financial Services for each quarter for auditing purposes.
Once an Encounter is listed on this report, it cannot be repeated. Follow up will have to be done with Medicare on an individual Encounter basis.

The person completing the quarterly report along with a supervisor’s signature signs an attestation form. This is kept with the department copy. The Vice President, Finance, also signs a separate attestation form. This form is sent to Medicare with the quarterly report.
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 allowances posted:

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

Behavioral Health will monitor grant funding.
SCOPE: Dunning and Collection

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

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

Medicare Encounters that have a self pay benefit order are forwarded to Pre-collection and are dunned in the same manner as self-pay patients.

Once the self-pay balance is referred to OSI, the patient will receive dunning messages and phone calls [on larger balances] following their process. If the Encounter 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 collection agency will follow the same collection processes for Medicare patients as they would for non-Medicare patients.

Medicare bad debts, which are deemed to be uncollectible, are reflected on the annual cost report.
**SCOPE:** Admissions

**PURPOSE:** To obtain complete demographic and financial information on all emergency and urgent patients in order to seek maximum and timely reimbursement from third-party payors and patients.

**POLICY:** All emergency, urgent admissions, urgent one-day stays are to be reviewed daily and third-party coverage verified as per the guidelines of the Insurance Verification Policy.

**PROCEDURE:**
Refer to Pre-Admission Policy and Insurance Verification Policy for guidelines by payor source.

For the emergency, urgent patients, timing is very important. Any coverage that require pre-authorization or pre-certification need to done immediately upon admission notification. Benefits should also be verified as quickly as possible, to inform patients of their out-of-pocket financial obligations.

Self-pay patients must be reviewed and payment determination made as soon as possible, to take advantage of welfare and/or other programs if necessary, due to timely filing requirements. This review is done by an R&B Medicaid Solutions liaison contracted by the hospital.

Patients who meet the criteria for entitlement are entered into the R&B system for aggressive follow up to include field visits and appeals if necessary.
### WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES

<table>
<thead>
<tr>
<th>CATEGORY: Credit and Collection Policies</th>
<th>POLICY: Patient Types / Admit Types</th>
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<tr>
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**SCOPE:** Patient Classification

**PURPOSE:** To identify the various types of inpatients and outpatients

**POLICY:** For purposes of clarification, the following terms are explained. They should not be confused with hospital services which are used for registration purposes and which identify specific areas or types of in-patients and out-patients.

### Patient Types

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td>A client is an entity to which patients are registered and billing occurs monthly by invoice.</td>
</tr>
<tr>
<td>Emergency</td>
<td>A patient who is treated in the Emergency Department for a condition or injury which requires immediate attention and who is not admitted.</td>
</tr>
<tr>
<td>Inpatient</td>
<td>A patient admitted to the hospital for an overnight stay, and provided room and board and continuous nursing services</td>
</tr>
<tr>
<td>Observation</td>
<td>An unplanned event during which the patient is monitored for possible admission.</td>
</tr>
<tr>
<td>Outpatient</td>
<td>A patient referred to an outpatient ancillary service/s by either a hospital-based physician or other private physician</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>An elective outpatient surgical case.</td>
</tr>
<tr>
<td>Preadmit</td>
<td>In-patients or out-patients who are pre-registered and/or scheduled for preadmission testing/autologous blood donation</td>
</tr>
<tr>
<td>Preadmit Recurring Outpatient</td>
<td>Used rarely if ever.</td>
</tr>
<tr>
<td>Recurring Outpatient</td>
<td>An outpatient who is treated for the same diagnosis on a recurring basis i.e. Behavioral Health, Cardiac Rehabilitation. etc.</td>
</tr>
</tbody>
</table>

### Admit Types

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective</td>
<td>Patients who are scheduled in advance for in-patient</td>
</tr>
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</table>
# WATERBURY HOSPITAL CREDIT & COLLECTION POLICIES

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Patients who are admitted via the Emergency Department.</td>
</tr>
<tr>
<td>Information Not Available</td>
<td>When the source of the admission is not known.</td>
</tr>
<tr>
<td>Newborn</td>
<td>Newborn admissions</td>
</tr>
<tr>
<td>Trauma Center</td>
<td>Patients admitted as a result of a Full or Core Trauma.</td>
</tr>
<tr>
<td>Urgent</td>
<td>An emergency/urgent admission sent from physician's office not seen in the Emergency Department</td>
</tr>
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</table>
**SCOPE:** Medicaid Entitlement  

**PURPOSE:** To identify self pay patients who will qualify for Medicaid/SAGA entitlement.  

**Policy:** R&B Medicaid Solutions is a contracted agency of Waterbury Hospital, responsible for the identification of self pay patients who will qualify for Medicaid/SAGA entitlement, and to aggressively pursue resolution of that entitlement.

**Procedure:**
- On a daily basis, the R&B liaison will identify self pay inpatients and outpatients from various sources: IP Self Pay Workqueue, Central Registration referrals of high-dollar outpatient services.
- Liaison will compile a list of patients to be interviewed and visit patients while in-house.
- Using their laptop, liaison will be able to determine if patients meet the categories for possible entitlement to Medicaid/Saga.
  - Qualified patients are entered into the R&B database
  - Patients with no category [over assets or undocumented aliens] will be given financial counseling information and passed back to Customer Service for follow up.
- As necessary, liaison will go into the field to obtain patient information [as directed by home office, Connecticut advocates].
- A file of all patients in the R&B database will be sent monthly to Waterbury Hospital and reconciled against the hospital HIS system.
- Waterbury Hospital will receive notification as follows:
  - Acknowledgements of patients entered into database
  - Entitlements for Medicaid/Saga
  - Accounts returned for various reasons such as “patient uncooperative”
- Liaison will work closely with Patient Access, Patient Accounts and Case Management for retro-authorization by Qualadigm for Medicaid/Saga patients.
- Liaison will also work closely with WHAP program on patients with spenddown and for entitlement to other services such as pharmacy benefits and food stamps.
SCOPE: Pre-Admission

PURPOSE: To ensure that accurate and complete demographic and financial information is obtained and verified in order to collect maximum reimbursement for every pre-admitted Encounter in a timely manner.

POLICY: All patients scheduled for elective admission, one-day stay, and selected outpatient services, are to be pre-admitted and have insurance coverage verified and authorized. [Please refer to the Insurance Verification Policy for specific information]

PROCEDURE:
At the time of reservation, and/or scheduling, the physician's office will provide Central Registration with payor sources and associated information.

THIRD-PARTY PRE-ADMISSION REQUIREMENTS:

TRADITIONAL MEDICARE: At this time, Waterbury Hospital is no longer required to call for prior authorization on any elective, non-emergency procedure. Eligibility verification, however, must be completed.

MEDICAID/SAGA ENTITLEMENT:
The Waterbury Hospital is contracted with R&B Medicaid Services to interview and qualify self-pay inpatients for entitlement to Medicaid/Saga. The R&B liaison will visit the patient on the floor and make an initial determination of qualification.

If after screening, the patient meets qualifications for Saga/Medicaid – an application will be filed will DSS. R&B will work aggressively to obtain all data necessary, including field visits, to complete the application and entitlement process.

If patient does not qualify – R&B will give the patient an application for consideration of free bed assistance. The R&B liaison will also give the patient the Free Bed Summary Handout as per state regulations effective 10-1-03.
Per the Insurance Verification Authorization Policy in the Admitting manual:

**Self Pay Admissions**
All self-pay admissions will be referred to R&B Medicaid Services. If after screening, the patient does not meet criteria for Medicaid/SAGA, R&B will give the patient information regarding uninsured, charity care, etc. The patient is considered self-pay and will be billed accordingly.

Non-citizens – patients who are not citizens are not eligible for coverage unless certain circumstances apply. [please refer to Alien Coverage Help Sheet]
If patient has not been in the United States for 5 years or more or does not qualify for entitlement under the Aid to the Aged, Blind and Disabled, there is no emergency coverage provided.

**MEDICAID AUTHORIZATION:** The State of Connecticut via the Concur Program, requires prior authorization for all elective, non-emergency in-patient admissions. Emergency/urgent admissions require review within two business days of admission. Any request for prior authorization not meeting these parameters will not be granted and the claim will not be paid.

Central Registration notifies case managers of Medicaid admissions.

A separate process has been developed to comply with Medicaid requirements regarding patients granted TXIX retroactively. Case Management, Patient Access & Patient Accounts collaborate to comply with these requirements.

There are several exceptions that do not require prior authorization as follows:
Maternity patients admitted for delivery
Newborns
Patients admitted and discharged on the same day [patients must be discharged prior to midnight]
However, if certain situations exist, an authorization IS required as follows:
Maternity patients who do not deliver within 48 hours
Maternity patients who are admitted for delivery if the baby is 36 weeks or less.
Newborns who are transferred to and from another hospital
Newborns with a Medicaid number

**WORKMAN'S COMPENSATION:** If possible, patients who are being admitted for services due to a work-related injury/illness are to submit a letter from their employer and/or attorney stating that this is a valid work-related case. A copy of the incident report is beneficial if obtained. The workers compensation case number is documented on the Encounter.

Since it is against the law to bill patients for non-disputed work-related injuries/illnesses, it is imperative that the validity of the compensation case is provided as soon as possible. Always obtain medical insurance in addition to workers compensation. Medical insurance must be verified and authorized.
COMMERCIAL INSURANCE/ COMMERCIAL HMOS/ ANTHEM BC/MANAGED MEDICARE:
Pre-admission authorization numbers are obtained and entered into the system [TAR numbers] by Central Registration/Scheduling. In most cases, the patient is HELD HARMLESS according to contract, for any penalties imposed by third-party payors for lack of pre-authorization or pre-certification, even though the patient is ultimately responsible for notifying payors.

Central Registration/Scheduling will, as a courtesy to the patient, and as a follow-up mechanism, validate that the third-parties were notified.

The hospital will notify all commercial insurance patients of any deductibles, co-pays and any other out-of-pocket expense via phone or in person. Patients are notified that their financial repayment obligations are to be met at the time of admission or upon discharge unless other arrangements have been approved. [please refer to the Discharge policy]

SELF-PAY: Complete pre-payment or approved payment arrangements will be requested prior to elective inpatient admissions. If a patient is unable to meet their financial obligations, a financial review will be done and the appropriate programs reviewed i.e. State or City welfare, etc.

For elective non-covered inpatient services a deposit will be required based on an estimation of charges. Selected outpatient services such as Virtual Colonscopy or CT Angiography will require payment prior to service being rendered.

For cosmetic services, full payment of the fee is expected prior to procedure.

Waterbury Hospital maintains the option of delaying elective, non-urgent services pending financial review, with the approval of the patient, admitting physician, and Chief of Services.
**POLICY:** In an effort to maximize cash collections, payments will be requested prior to service by the ERM staff with a follow-effort by the PAFS Customer Service staff. At time of scheduling if a self-pay patient is identified a payment will be requested.

Cosmetic surgeries are priced according to a fee schedule and patients are expected to pay the fee in full prior to surgery.

**PROCEDURE:**

**Cosmetic Procedures:**
Refer to the Pre-Paid Cosmetic Procedure policy and form in the Registration/Access Manual for complete procedures and form.

**Other Services:**

**Process:** A script was developed to provide guidance to the ERM staff in their efforts to collect cash. The following script will be used to assist the staff.

"I understand you are a self-pay for this service and you received a payment notification form from your doctor for an estimation of cost."

- Have you made that payment yet?
- If yes, call will be ended
- If the patient states check to be mailed, call is ended
- If no payment to date has been made the registrar will remind the patient/caller that payment is expected 72-hours prior to service
- If the patient is ready to pay by credit card (Visa, MasterCard, Amex, Discover) the registrar will give the patient the encounter number and transfer the patient/caller to: Customer Service at Extension 7116 for payment

If the patient is unable to make payments or requires Financial Assistance a Customer Service representative will assist the patient with payment plans or programs offered by the hospital.
SCOPE: Price Quoting

PURPOSE: To provide estimated prices to patients upon request

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

The following letter is used to confirm estimated price for services. [Please refer to individual document Price Quote Letter.doc for use with patients]
Estimated Price of Medical Procedure/Treatment

Dear ____________________:

On _____________________ you contacted the Waterbury Hospital Health Center and requested the **ESTIMATED PRICE** of the following treatment.

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

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

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

Sincerely,

Patient Financial Services Representative

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

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

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

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

The message on self pay demand and summary bills will be modified to refer to Public Act 02-92 and inform self pay inpatients that they may, upon request, receive a full itemization of all charges.

Waterbury Hospital Health Center shall provide the patient with an itemized bill not later that thirty [30] days after the date of such request.
SCOPE: To define reasonable efforts for collecting patient due balances

PURPOSE: To complement the various other policies relating to the collection of patient due balances.

POLICY:
It is the policy of Waterbury Hospital to extend collection efforts which are reasonable and compliant with state and federal guidelines on the referral of patient due balances to a collection agency.

[Note: Patient due balances are defined as deductibles, coinsurances and co-payments as adjudicated by third parties. Patients who have no insurance are considered to be responsible for full charges.]

At time of discharge [to include expirations] or conclusion of outpatient services, Encounters are placed in suspense for a specified number of days to allow charges to be posted and other functions such as coding, to occur. In-patient Encounters, for example, are held for a minimum of 5 days, outpatients for 8 days.

Once the minimum days have been exhausted, a final bill will be created dependent on the resolution of all billing edits.

Reasonable Collection Effort:
• The bill will be generated and sent to the third party payer or patient, if the patient has no insurance.
• Self pay Encounters are referred to an outsourcing agency which acts as an extension of the business office.
• Once payment has been received from primary payer and the deductible and coinsurance has been identified, the patient will be billed for any remaining balances. Self pay balances after insurance are also referred to an outsourcing agency.
• Self-pay patients receive a series of 3 statements at approximately 30-day intervals, from our outsourcing agency. The statements are progressive in informing the patients of their obligation, to include notice of referral to outside agencies if unpaid.
• Insurance and self-pay follow-up, including outbound IVR, phone calls, etc. is also performed
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CREDIT & COLLECTION POLICIES  

At any point along the collection cycle a patient can inquire and/or request to be considered for a variety of discounting and free bad programs. Signage is posted in all registration and Customer Service areas as well as provided to self-pay patients at time of service. In addition, all statements provide information on the back of the invoice, on how to access financial counseling assistance.

After the final statement has been sent to the patient, the outstanding amount that pertains to Deductible or Co-payment will be reviewed and a determination as to the next step will be made based on the following criteria:

Waterbury Hospital will refer uncollected patient charges of like amount to a collection agency unless it has been determined that the patient is Indigent or Medically Indigent as per hospital policies.

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

For all other patients, the Waterbury Hospital will apply customary methods for determining qualification of patients for the various discounting and free bed programs available. It is important to note the following:

The patient’s indigence will be determined by Waterbury Hospital and not by the patient. Waterbury Hospital will take into Encounter 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. Waterbury Hospital must determine that no source other than the patient would be legally responsible for the patient’s medical bill (i.e. Title XIX, Welfare, etc.)

The Patient’s file should contain documentation of the method with which indigence was determined in addition to all backup information to substantiate the determination.

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

**Medicare Bad Debts under State Welfare Programs**- Effective with the 1967 Amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically or medically needy persons. Any portion of such deductible or coinsurance amounts that the State is not Obligated to pay can be included as bad debt under Medicare, provided that the requirements for determining indigent or medically indigent have been applied and met or if the patient meets other collection efforts as noted above.
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SCOPE:
PURPOSE: To ensure that reasonable collection efforts are established for self-pay deductions, copays, co-insurances and other outstanding patient due balances.

POLICY: Reimbursement of Self-Pay Balances

PAGE: 34
ORIGINATED: 12/5/97
REVIEWED: REVISED: Jul-03, Mar-04, Jan-07, Dec 2007
RETIRED:

POLICY: To collect self-pay balances in a timely manner, from any point during the revenue stream up to and including referral to collection agencies.

PROCEDURE:

PREADMISSION:
For all pre-admissions, emergency, urgent, elective, maternity and one-day surgery, the following guidelines will apply for each payor source:
Self Pay
- Non-covered elective admissions and tubal reversals will require a deposit of estimated charges.
- Cosmetic surgeries will require full payment within 72 hours prior to service.
- Third-party - patients will be requested to pay estimated deductibles, co-pays and co-insurance amounts based on verification of coverage prior to admission or at time of discharge.
- Medicaid - patients with state or city welfare are not required to make cash payments prior to admission.

POST DISCHARGE:
At time of discharge [to include expirations] or conclusion of outpatient services, Encounters are placed in suspense for a specified number of days to allow charges to be posted and other functions such as coding, to occur. In-patient Encounters, for example, are held for a minimum of 5 days, outpatients for 8 days.

Once the minimum days have been exhausted, a final bill will be created dependent on the resolution of all billing edits.

FINAL BILL:
A final bill is created and submitted either electronically or by hardcopy to all primary third-party carriers and to patients if there is no insurance listed.
- Self pay patients receive an itemized statement at time of final bill.
- Any patient can request an itemized statement at any time.
When the insurance payment is received, the Encounter is reviewed and the appropriate contractual allowances are processed as applicable. The liability for the remaining balance becomes the responsibility of secondary or tertiary carriers or the patient for deductibles, coinsurances or co-pays.

OUTSOURCING AGENCY – Extended Business Office:
Self-pay balances from day one and self-pay balances after insurance are referred to an outsourcing agency. Encounters are reviewed and patients are dunned as per the OSI self pay workflow.
- If a self-pay day one patient provides insurance information, the Encounter is reclassified and billed to the insurance carrier. The Encounter will remain with OSI for third-party follow up.
- Self-pay patients receive a series of 3 statements at approximately 30-day intervals.
- Patients who are on repayment contracts will receive monthly statements until the balance is resolved.

Insurance and self-pay follow-up, including outbound IVR, phone calls, etc. is also performed.
On-site outsourcing liaisons complete daily work lists of Encounters requiring review and action. The liaisons work in both the hospital and outsourcing computer systems.

PATIENT STATEMENTS:
For Encounters which are not outsourced or that are returned from the outsourcing agency and which require statements:
- Encounters are placed in a Manual Statement dunning level
- Self-pay patients receive 4 statements at 30-day intervals.

REPAYMENT CONTRACTS:
The Patient Encounters staff and the outsourcing agency will always attempt to collect the full amount due on every self-pay Encounter. If however, the patient is unable to pay the full amount, a repayment contract can be initiated according to established guidelines.

INDIGENT OR MEDICALLY INDIGENT PATIENTS:
At any point in the revenue stream, patients may inquire or request to be considered for eligibility for free bed funding or discount programs. [see the following associated policies:
  - Self-Pay Discount Policy
  - Uninsured Patient Policy
  - Patient Assistance Policy
  - Charity Care Policy

Please refer to the Collection Agency Referral Policy for guidelines on delinquency and collection agency referral.
SCOPE: To understand the third-party billing process
PURPOSE: To outline the steps required prior to and at the time of third-party billing.
POLICY:
It is the policy of Waterbury Hospital to prepare claims according to established third party and internal guidelines: to perform timely filing of claims with third parties and patients.

At time of discharge, the benefit order status is ready to bill. When an Encounter is in ready to bill status, it is held for a minimum number of days depending on category before the system tries to bill the Encounter. The following is the minimum number of days, Encounters are held in Suspense:
Inpatients 5 days after discharge
All others 9 days after discharge

THE PURPOSE OF HOLDING ENCOUNTERS IN “SUSPENSE” IS TO ALLOW TIME TO PERFORM THE FOLLOWING FUNCTIONS:
- HIM coding
- Charge entry [charges can be posted at any time along the cycle]
- Satisfy compliance checks such as IP/OP overlaps, etc.
- Changes to information prior to final bill

Once the minimum number of days have been satisfied, the Encounter is ready to bill. There are numerous edits built into the system to catch problem areas such as missing demographic and diagnosis, missing authorizations, etc. If an Encounter cannot bill due to an edit, it will appear on the Corrections Requiring Edit report. This report is distributed to users on a weekly basis. Once all edits are resolved, the claims are regenerated.

When the Encounter is final-billed, the claim status changes to Submitted. Support Services staff download electronic billing files to their desktop pcs for claim “scrubbing”, based on third-party:
The following carriers are electronically scrubbed and billed via the SSI Click-On Claim Module in HIPAA-compliant format:

- Medicare Part A – hospital
  - Compliance to various Medicare requirements regarding IP/OP overlapping bills, Non-Coverage letters, Medicare Secondary Payer questionnaire etc.
- Medicare Part B - physician fees [First Coast]
- Commercial and Managed Care payers – various large commercial payers
- Medicaid – traditional

Anthem Blue Cross
Anthem is billed electronically via PC-ACE software.

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

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

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

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

Support Services staff utilize follow-up reports for Encounter analysis. It is not uncommon for third-parties to NOT receive a claim for various reasons. Many Encounters have no payment or denial ever received. These Encounters are worked based on high dollar. Other follow up processes:
Denials are received and reviewed via the remittance [electronic or hardcopy]
Correspondence is received and handled.
Patient calls or walk-ins present billing concerns.
New/changed insurance information is obtained.
Encounters are rebilled as necessary.

Once an Encounter is billed to the third-party, the Encounter remains in AR status until it is resolved by payment or turned over to an outside collection agency. [See associated policies]
POLICY: It is the policy of Waterbury Hospital to define and verify the payment source accurately, for each encounter.

There are several sources of payment as follows:

I. PATIENT
The primary responsibility for payment of the Encounter always rests with the patient. All patients will be required to sign a patient agreement prior to admission or at time of registration. The patient agreement contains the assignment of benefits.

In any controversy, default or misrepresentation, the hospital will always seek payment from the patient. In the event of special contract situations, workers compensation or state/federal regulation releasing patients from responsibility, payment will be sought from the appropriate third-party agent, if applicable.

Unpaid patient balances result in increases in the cost of patient care, therefore, the patient portion of the hospital bill, whether it is the full bill in the case of self-pay, or balances after insurances have paid, are to be satisfied thru one or more of the following resources:

- Cash, money orders, personal checks, travelers checks [U.S. currency]
- Credit cards acceptable to the hospital - Mastercard, Visa, Discover, American Express
- Savings Encounters, income tax refunds
- sale of investments, conversion of insurance policy
- loans from banks, credit unions, finance companies, etc.

Waterbury Hospital will request payment of co pays and/or deductibles prior to admission or at time of discharge, based on verification/authorization.

Maternity patients and other elective patients may make payments in advance of their admission.

Full payment of estimated charges is required within 72 hours prior to admission for cosmetic surgery. Tubal reversal and other non-covered procedures will require a deposit of estimated charges prior to service.
II. THIRD-PARTY COVERAGE

Government Payors
Medicare – It is the policy of Waterbury Hospital to bill Medicare, Managed Medicare and Medicare patients per the guidelines set forth in the HIM-10 Medicare manual, and subsequent changes to policies, procedures, etc., as directed by the fiscal intermediary for Waterbury Hospital – Empire Blue Cross of New York.

Medicaid [State/City] – It is the policy of Waterbury Hospital to bill Medicaid as per the instructions set forth by the Department of Income Maintenance for the state of Connecticut.

Contracted Payors [HMOs, PPOs etc.]
It is the policy of Waterbury Hospital to bill contracted payors and patients according to the terms and guidelines set forth in contracts and payor manuals.

Other Third-Party Payors -
It is the policy of Waterbury Hospital to bill all third-party coverage as a courtesy to the patient upon validation of benefits and assignment of payment to the hospital and to abide by any prompt pay discount arrangements.

III. UNCOMPENSATED FREE CARE:
Waterbury Hospital recognizes its responsibility to those patients who are unable to pay for services rendered due to financial hardship, and who do not qualify for State or City Welfare programs. Free bed funds and other programs, are available for those patients who meet established criteria. Application can be made with Customer Service [Financial Counseling] after services are rendered.

Available programs include:
- Patient Assistance Committee - approved Encounters are put towards Free Bed Funds
- Sliding scale
- Public Act 94-9 [uninsured patients]
- Charity Care - Usually small dollar amounts that are not presented to Patient Assistance Committee for deceased/indigent patients
- Repayment contracts.

Waterbury Hospital will cooperate with all third-party payors and patients to the fullest extent in order to facilitate the collection of all balances due.
Policy: It is the policy of Waterbury Hospital to resolve open balances via repayment plans within a reasonable time period.

Procedure:
Informal Payment Plans
Informal plans are assigned automatically by the HIS system when a patient makes a payment that is less than the total balance due and a formal payment plan has not been established.

Informal plans follow the Self Pay statement cycle flow.

Unpaid balances will flow to our outsourcing agency for further collection efforts and on to collection agencies if not paid, following routine guidelines.

Formal Payment Plans
Formal payment plans are set up within the HIS system for a specific amount to be paid on a monthly basis, starting on a specific date.

The statement flow reacts to payment and non-payment according to the Formal Payment Plan cycle. [see Statement Handbook]
WATERBURY HOSPITAL
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Re-Payment Guidelines

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<th>Re-Payment Period</th>
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<td>$ 0 – 25.00</td>
<td>In Full within 30 days</td>
<td>In Full</td>
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<tr>
<td>$26.00 - $100.00</td>
<td>In Full within 60 days</td>
<td>Balance / 2</td>
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<td>$101.00 - $300.00</td>
<td>In Full within 6 months</td>
<td>Balance / 6</td>
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<tr>
<td>$301.00 - $1000</td>
<td>In Full within 12 months</td>
<td>Balance / 12</td>
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<tr>
<td>$1000 - $5000</td>
<td>In Full within 24 months</td>
<td>Balance / 24</td>
</tr>
<tr>
<td>$5000 - $10,000</td>
<td>In Full within 30 months</td>
<td>Balance / 30</td>
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<tr>
<td>&gt; $10,000</td>
<td>In Full within 36 months</td>
<td>Balance / 36</td>
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Any re-payment plans are not to extend beyond 36 months.

Patients who are unable to make payments in accordance with the above guidelines must fill out a financial application form.
- If the patient complies and qualifies for sliding scale discount, discount will be applied.
- If the patient complies and does not qualify for sliding scale discount, they must adhere to the repayment guidelines above.
- If the patient does not comply, they will be notified that we cannot enter into a formal plan.

Patients cannot dictate to Waterbury Hospital, what is an acceptable payment. To set up a payment plan that would beyond extend 36 months is to effectively provide the patient with an interest-free loan. This is not acceptable.

Customer Service will make every effort to work with a patient to determine an affordable plan within the guidelines above. A combination of payment options can be established, for example, a lump sum payment with repayment on remaining balance.

Further collection efforts will be warranted for those encounters which remain unpaid or are not set up in acceptable re-payment plans.
POLICY: Co-pay collections initiatives

CATEGORY: Credit & Collection

ORIGINATED: 10-22-07

SCOPE: Maternity admissions & AM admits Dates of service: 11/12/07-forward

PURPOSE: Co-pay collections

POLICY: In an effort to maximize cash collections, payments will be requested prior to service by the ERM staff with a follow-effort by the PAFS Customer Service staff. At time of scheduling if a co-payment is identified a payment will be requested.

Process: A script was developed to provide guidance to the ERM staff in their efforts to collect cash. The following script will be used to assist the staff.

Thank you for choosing Waterbury Hospital for your Healthcare needs, it has been determined by your insurance company _name__ that you have a co-payment of $250.00, for this admission. How will you be paying for this today? We accept: Visa, MasterCard and American Express.

Maternity:

- Pre-admit form needs to be referred to Nadine Velez by Front end Registration staff
- Nadine will verify primary insurance and obtain co-payment amount for this admission. If 2ndry or tertiary insurance apply no pre-service collections required
- All comments will be noted on the front of the admit form in red ink.
- Admit form goes back to front end registration for pre-admit registration to occur
- Registrar will be required to contact the patient advising of co-payment due for admission 72-hours prior to admission.
- Registrar will be responsible to collect co-payment over the phone: Scripting: Thank you for choosing Waterbury Hospital for your Healthcare needs, it has been determined by your insurance company _name__ that you have a co-payment of $250.00, for this admission. How will you be paying for this today? We accept: Visa, MasterCard and American Express.
- If partial payment is made the follow-up on the balance will need to be done by Patient Accounting/Customer Service
- In Nadine’s absence Sharon Garner will be responsible to do
**AM admissions which includes: C-section deliveries:**

- Pre-registration team working on fax machine will need to refer reservation fax to pale green file folder labeled: C-Section AM’s to do: Sharon Garner will pull daily.
- Sharon will verify primary insurance and obtain co-payment amount for this admission. If 2ndry or tertiary insurance apply no pre-service collections required
- All comments will be noted on the front of the reservation form in red ink
- Reservation form goes back to pre-registration area in the yellow file folder labeled-completed AM’s-sections and the fax person will delegate as alpha assigned for pre-registration to occur
- If Sharon identifies during verification the insurance is incorrect or terminated the reservation form goes back to pre-registrar who will obtain the correct information
- Reservation form goes back to Sharon for verification and co-payment determination (repeat of process bullet #3 and #4 above)
- Registrar will be responsible to collect co-payment over the phone: Scripting: Thank you for choosing Waterbury Hospital for your Healthcare needs, it has been determined by your insurance company ___name___ that you have a co-payment of $250.00, for this admission. How will you be paying for this today? We accept: Visa, MasterCard and American Express.
- If partial payment is made the follow-up on the balance will need to be done by Patient Accounting/Customer Service
- STAT orders put on Sharon’s desk
- Add-on orders put on Sharon’s desk
- Sharon’s absence – Nadine to cover

If the patient is unable to make payments or requires Financial Assistance a Customer Service representative will assist the patient with payment plans or programs offered by the hospital.
POLICY: Cash Collections

CATEGORY: Credit & Collection

ORIGINATED: 10/01/2007

PAGE (s): 1

OWNER: Central Registration

REVISED:

APPROVED BY: 

RETIRED:

SCOPE: Cash Collections Prior to Service

PURPOSE: Self-pay collections

POLICY: In an effort to maximize cash collections, payments will be requested prior to service by the ERM staff with a follow-effort by the PAFS Customer Service staff. At time of scheduling if a self-pay patient is identified a payment will be requested.

PROCEDURE: A script was developed to provide guidance to the ERM staff in their efforts to collect cash. The following script will be used to assist the staff.

I understand you are a self-pay for this service and you received a payment notification form from your doctor for an estimation of cost.

- Have you made that payment yet?
- If yes, call will be ended
- If the patient states check to be mailed, call is ended
- If no payment to date has been made the registrar will remind the patient/caller that payment is expected 72-hours prior to service
- If the patient is ready to pay by credit card (Visa, MasterCard, Amex, Discover) the registrar will give the patient the encounter number and transfer the patient/caller to: Customer Service at Extension 7116 for payment

If the patient is unable to make payments or requires Financial Assistance a Customer Service representative will assist the patient with payment plans or programs offered by the hospital.
POLICY: Cash Collections in the Emergency Department

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SCOPE: Cash Collections

PURPOSE: Self-pay collections for ED patients on discharge.

**POLICY:** It is the policy of Waterbury Hospital to inform ED patients of copays balances prior to discharge from the ED and to collect these payments whenever possible.

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

Morning Procedure

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

Credit Cards
- WHHC accepts American Express, Discover, Visa and Master Card
- Swipe credit card using sales slip.
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CREDIT & COLLECTION POLICIES

- Check expiration date
- Write “ED Visit” in the description field.
- Enter amount of co-payment in the “Amount” field.
- Enter Date
- Enter account number in “Reference No.” field.
- Place your initials in the “Clerk” field.
- Circle credit card type. (MC, Visa, etc.)
- Have patient sign if possible.

- Complete receipt from receipt book entering:
  - Date
  - Patient’s name
  - Patient’s address
  - Amount of payment
  - For: ED Co-payment, WHHC
  - Place account number in the section under “For”.
  - Enter credit card type in the “Notes” section. (MC, VISA, etc.)
  - Sign
- DO NOT give patient the credit card sales slip receipt or handwritten receipt. Please explain to them, the hospital cashier will mail all receipts to them after processing.

- Staple both receipts together and place in cash drawer.

- Be sure to verify patient address and update in system if needed.

**Checks**
- Checks should be made out to Waterbury Hospital.
- Complete receipt from receipt book entering same information as with Credit Cards except credit card type in the Notes section.
- Enter check number in the “check field”.
- Give patient receipt.
- Place check in cash drawer.

**Cash**
- Fifty dollars will be kept in the cash drawer for change.
- Complete receipt entering all information described in the Credit Card section.
- Enter the amount of cash received in the “Cash” field.
- Provide patient with receipt.
Balancing

- Make a tape of all cash transaction and total, all Credit Card transactions and total, and all Check and total. Leave $50.00 in the cash drawer as follows:
  - 10 ones
  - 6 fives
  - 1 ten
  (If the exact denominations are not available, change can be made the next morning in the cashier’s office.)
- Cash should be counted and added by domination.
- Add total of credit card, cash, and check payments together.
- Make 2 copies of receipt book for your transaction and highlight payment amount.
- Add amount of receipts together.
- Total of cash, credit card and check payments should equal the total amount of receipts.
- Staple adding machine tape to one copy of the receipt book signing your name.
- Have another registrar check your addition, producing another tape.
- Attach the second tape to one copy of the receipt book having the second person sign their name to both receipts.
- Place all payments and one copy of receipts with tape attached in the blue cash bag. Label the $50.00 start money and also place in bag and lock.
- Bring blue Case bag to the Operator’s office off the front lobby. The Cashier will pick up in the morning.
POLICY: Elective Private Pay Patients

CATEGORY: Credit & Collection Policies

ORIGINATED: October 2007

SCOPE: Private Pay patients planning inpatient treatment at Waterbury Hospital.

PURPOSE: To provide a mechanism for elective self pay patients to negotiate rates comparable to an insured patient when inpatient treatment is elective but medically necessary.

POLICY: It is the policy of Waterbury Hospital to work with elective self pay patients to provide them with reasonable estimates for inpatient surgical procedures based on third-party contracted rates.

PROCEDURE:
Patients inquiring about elective procedures which are:

- not emergent
- medically necessary

And who:

- have no insurance
- wish to pay a rate of reimbursement similar to a third-party.

- A rate of payment will be given to the patient based on the specific procedure to be performed and the average of the payment rate for that procedure from our contracted commercial PPO payers as determined by our managed care department.
- Patient will be expected to pay 50% prior to service [when procedure is scheduled] and the remainder at admission.
- Remainder of payment is due at admission.

When the rate is paid in full, the balance will be written off as Self Pay Prompt Pay Adjustment – alias 2013.

IMPORTANT NOTE:
The risk of not getting paid from a self pay is much greater than from an insurance company. Our negotiated rate with insured companies is based on the fact that we get paid in full. So – terms should be set that ensure collection of the encounter within similar limits, with minimal flexibility.

To:
Re: SELF PAY ELECTIVE SERVICE

Dear Patient:

We have provided you with a good faith estimate of charges associated with the following procedure which you may choose to be performed at Waterbury Hospital at a future date [within 3 months of this letter].

Procedure ___________________________________________________________

We are also providing you with a reimbursement amount * of $____________________________ for this service which will be payable as follows:

- 50% When Procedure is Scheduled
- 50% Upon Admission

* It is important for private pay patients to understand that “contracting” for a reimbursement rate similar to a third-party payer is patient based on the specific procedure to be performed and the average of the payment rate for that procedure from our contracted commercial PPO payers as determined by our managed care department.

Thank you for allowing us to provide your care. Please contact me for any questions/concerns by phone or email. Please send the initial 50% payment to my attention and bring the remainder on day of admission.

Phone:______________________________

Email:______________________________

Patient Access / Financial Services
SCOPE: OSI is utilized for self-pay day one, self pay after insurance and third-party collections to include on-site liaison assistance.

PURPOSE: To provide support to the Patient Encounters/Financial Services department for the dunning and collection of self pay balances and selected third-party Encounters.

POLICY: Waterbury Hospital has entered into a contractual arrangement with OSI for the purposes of self-pay and selected third-party collection services.

PROCEDURE:
On a daily basis, new Encounters are electronically transmitted to OSI. With few exceptions, the majority of Encounters is self-pay day one, and self-pay balances after insurance.

Encounters are loaded into the OSI system and patients are dunned. OSI staff off-site is responsible to handle all incoming patient phone calls.

If insurance information is received, the Cerner system is updated and a bill generated to the carrier. The Encounter remains with OSI until it is resolved either by payment, or returned for collection or other resolution [write-off, small balance, charity care etc.).

OSI utilizes an outbound IVR for follow up phone calls, as well as other routine collection efforts: [phone, statements]

Electronic files are sent/received to/from OSI as follows:
- Daily – transaction file
- Daily – new business files [Wednesdays and Fridays]
- Weekly – Reconciliation file
- Daily- Returned Encounters are uploaded into the hospital system

Monthly reports are produced for all Encounters that have been returned that are not considered bad debts. Waterbury Hospital staff works these Encounters.

Encounters that are returned for bad debt collection are identified by specific cancel codes. These Encounters are then referred to collection agencies dependent on specific criteria. [See Collection Agency Referral policy].

Currently, one full-time liaison is on-site to assist Waterbury Hospital staff and OSI off-site staff.
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On a monthly basis, Waterbury Hospital management and OSI management follow an action plan agenda via conference call, to stay on top of all issues.

Comments from the OSI system will be uploaded to Cerner at a future date.

OSI provides monthly status reports of all activity as well as a monthly IVR and statement report.

COMPENSATION
OSI is contracted with Waterbury Hospital for payment based on contingency. All monies are collected by Waterbury Hospital. On a monthly basis, OSI presents an invoice reflecting all Encounters paid in the prior month with associated fees.
SCOPE: To define a process for identification of patients who are treated for sexual assault and subsequent billing of specific items/services to the Chief State’s Attorney Office [CSA]

PURPOSE: To obtain reimbursement from the state of CT for these patients for the defined services and to comply with state regulations.

POLICY:
It is the policy of Waterbury Hospital to identify sexual assault victims for purposes of appropriate billing as per state of Ct regulations.

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

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

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

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

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

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

This process will be updated when new billing and review procedures are received from the CSA
SECTION II: FREE CARE MANUAL
SCOPE: Determination of when charity care is appropriate.

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

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

PURPOSE: To provide a mechanism to identify patients/Encounters that are uncollectible due to various reasons, most notably deceased, no estate, no assets, homeless and all reimbursement and assistance options have been exhausted. Due to the aggregate balance/s totaling under $1000, presentation to the Patient Assistance Committee is not deemed to be necessary. These Encounters can be written off to Charity Care or the appropriate free bed fund without committee approval.

Encounters which fall into the above categories and in aggregate, total $1000 or under, can be written off to charity care or appropriate free bed fund.

PROCEDURE:
When faced with one of the above situations, the Patient Financial Services Staff will do the following:
Prepare an allowance sheet with the appropriate Encounter numbers, documentation and summary bill.
When submitting for a deceased patient, obtain a copy of the death certificate and/or verification from an authorized person i.e. relative, conservator, or caregiver. Estates must be verified by a phone call to the Probate Court of the city/town of residence. Some of the local probate numbers are: Waterbury 755-1127, Naugatuck 729-4571, Southbury 262-0641.
OSI will send out the short application used for the Self Pay Discount policy on aggregate balances up to $1000.
When these forms are received back, the customer service rep will review the OSI Encounters along with any outstanding Cerner Encounters to determine if patient assistance should be pursued.
On a weekly basis, the supervisor, Customer Service, will review all Encounters submitted for charity care.
If the Encounter falls into a category for one of the free bed funds, then the balance will be written off to that fund using the appropriate procedure code and recorded as a utilization of that free bed fund for Encountering purposes.

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

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

*Differences between Charity Care and Bad Debts:*

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

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

**PURPOSE:** To insure that all information is collected in order to determine if a patient qualifies for financial assistance.

**POLICY:**

**CHECKLIST FOR FINANCIAL ASSISTANCE**

- ________ Proof of Residence (rent receipt or letter from landlord or others)
- ________ Proof of Debt (ALL BILLS OWED)
- ________ Last 13 weeks wage stubs or letter from employer
- ________ Copy of SS or SSI or other benefit check or letter from agency
- ________ Copy of child support check.
- ________ Most current Income Tax statement
- ________ Proof of assets
- ________ Bank Encounter statement or savings passbook (LAST 3 MONTHS)
- ________ Stocks
- ________ IRA’S
- ________ Bonds
- ________ Life insurance policies
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CREDIT & COLLECTION POLICIES

__________ Car registration

__________ Copy of Title XIX referral (W-1 form)

__________ Copy of City Welfare referral

__________ Alien registration card or other proof of alien status

__________ Other ____________________________________________

__________ Other ____________________________________________

__________ Other ____________________________________________
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.
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.

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.

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:

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**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
WATERBURY HOSPITAL
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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. We are also available to assist you with the Medicaid/SAGA application process.

- 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.

You may request to have your case presented to the Patient Assistance Committee of Waterbury Hospital. The Committee has the authority to grant free bed funds based on financial and personal need. To obtain further information, including an application, please contact our customer service representatives. [see above for contact information]

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.

Additional support is also available to you through your town’s social service and public health department. With your written permission, your town representative can assist you with our application process, as well as determine if you qualify for any other assistance programs such as Food Stamps, Husky program, CONNPACE, etc.
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 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.

Usted puede solicitar que su caso sea presentado al comité de asistencia al paciente en el Hospital. El comité tiene la autorización de darle “Fondo de Cama Gratis” basados en su ingreso personal o financiero.

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

LAS OFICINAS DE ASISTENCIA AL PACIENTE ESTÁN 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 el balance de su cuenta pendiente.

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

Con su autorización, un representante del estado podrá asistirle en el proceso de dicha aplicación, determinando si califica para otros programas de asistencia, por ejemplo, el programa de alimentos, Husky Program, y CONNPACE.

Gracias,
El Hospital de Waterbury
New Handout For Information On Free Bed Funds And Uninsured As Required By The State Of Ct, SB568

Effective October 1, 2003
The information sheet will have a form number CN4457 and will be available in the storeroom. Each department can order their own supply. Please order a supply to be ready for October 1st.

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

All self pay patients must be handed the information sheet at time of registration.

Q: What do I say to the patient?
Registrar: “Per the state of Ct, we are providing you with information regarding discount programs and free bed funds”

Q: What are free bed funds?
A: Free bed funds are donations made to the hospital to be used for inpatient and outpatient medical care to patients who qualify.

Q: How do I know if I qualify?
A: It is an application process. Call the number on the information sheet or stop by Customer Service to speak to a customer service representative.

Q: I am uninsured. How do I get a discount?
A: You need to meet certain guidelines per the state of Ct that are listed on the information sheet. Call the number on the form or stop by Customer Service to speak to a customer service representative.
Other information:
Self pay patients who are scheduled in advance
It is not necessary to send this out to scheduled patients. They will be informed by Central Scheduling of payment obligation.

Lab specimens
Lab specimens that are sent here to be analyzed are registered with the demographic information provided by the physicians’ offices. Self-pay patients will receive statements. The statement backer will have this information.

Signage in English and Spanish
Must be posted in all registration areas and in Customer Service. The new signs should be here next week. They are 24”W x 44”L and must be posted by October 1st. You will be contacted when the signs have arrived. Please take down the old sign and replace with the new one.
Patient Assistance Committee Bylaws

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 Financial Services. The Chairperson shall have the responsibility of maintaining accurate records for patient Encounters and allocation of Free Bed Funds. The Chairperson shall be a voting member of the Committee.

B. SECRETARY

This individual shall be appointed by Chairperson and shall have the responsibility for the agenda, recording, typing and distributing minutes. (The Secretary shall maintain permanent file copy of the minutes and all other reports.)
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The Secretary shall also be responsible for preparing cases and is not a voting member of the Committee.
The Secretary is appointed by the Chairperson of the Patient Assistance Committee.
The Secretary is responsible for communicating the decisions of the PAC to applicants in writing in a timely manner.

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 Financial Services
Social Services / Managed Care
Chase Outpatient Center
Risk Management
Nursing
Psychiatry

ARTICLE IV - MEETINGS

SECTION 1. MONTHLY MEETINGS

The Patient Assistance Committee will meet monthly, providing there are cases to be heard. 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 Secretary shall distribute a reminder of the meetings in advance of the meeting date. Meetings are scheduled for the first Wednesday of each month, at 8 a.m.

SECTION 3. AGENDA

The Secretary shall distribute a written agenda (along with the meeting notice) prior to the meeting date. The agenda should include both the reviews of old business and the
subjects to be discussed under new business. Also included in each agenda will be the review of the previous meeting minutes.

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 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.

APPROVED:

_____________________________________
VICE-PRESIDENT, FINANCE

_____________________________________
CHAIRPERSON, PATIENT ASSISTANCE COMMITTEE

DATE REVISED: January 8, 1998, April 1999
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 Encounters 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. Additional funding may be available on an annual basis.

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 State or City Welfare, State of CT Uninsured Status, 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 review

- 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 meet all criteria for uninsured status.

- Patients who have applied for government assistance and were denied [including timely filing denials] but 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 Encounters, medical bills, cable bills etc.
  - Proof of assets i.e. checking and saving Encounters
- 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.
WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES

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 verbally summarize for the PAC the financial situation and the Encounters eligible for free care.

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 14 business days.

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 mailed in confidential packets, to the committee members so that the committee may review the material prior to the next meeting.

Patient names are removed and each case is given a number.

The Patient Assistance Committee meets on the first Wednesday of each month. [See Patient Assistance Committee Rules and Regulations 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.
  o 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.

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 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.

All Free Bed Fund applications, whether approved or denied, will be recorded in an Access database for the purpose of compiling data for annual OHCA filings [see guidelines].

The PAC secretary will maintain minutes of each meeting to be kept on file.
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. If the Encounter was returned from OSI, and patient is to start receiving statement, the statement cycle will be changed to Manual and all holds removed.
SCOPE: Provide a mechanism to discount self pay balances.

PURPOSE: To offer options to self pay patients who may have difficulty resolving open balances.

**POLICY:** It is the policy of Waterbury Hospital Health Center to provide opportunities for the self-pay patient to receive a discount based on prompt payment and income/family size.

**PROCEDURE:**

Patient Assistance is always an option for the patient who states they cannot resolve their outstanding balance/s. An application is required in all cases. The patient will be required to attest to the validity of information and documentation by signing the Financial Application form.

Patients will be screened to see if they will qualify for any assistance programs.

**DISCOUNT OPTIONS:**

**PROMPT PAY DISCOUNT**

For patients with NO insurance, a prompt pay discount of 25% will be applied for full payment of the full outstanding balance within 30 days of receipt of first statement. This discount requires no financial application.

The following message will be reflected on the first statement effective March 1, 2008 –

*Please inform us if you have insurance coverage. If you have NO insurance coverage and the balance is paid IN FULL within 30 days, you may qualify for a discount. Please call 1-800-600-0407 for details: Monday – Friday, 8am – 4:30pm. Thank You.*

Patients who call the number on the statement will be speaking with our outsourcing agency that will inform them of the 25% discount and give them the adjusted balance. If the patient agrees to pay, a hold will be placed and monitored. When the patient has paid, the encounter will be put into a special disposition code which will alert our on-site liaison to put thru the allowance.

For patients who are unable to pay the balance in full within 30 days, the financial application process will be followed for qualification for sliding scale or other programs.
SLIDING SCALE MATRIX
The sliding scale matrix will be utilized for patients who cannot resolve their balance within 30 days or who have balances after insurance. Waterbury Hospital utilizes the Federal Poverty Income Guidelines [FPIG] for development of the sliding scale matrix. [The FPIG is updated annually usually in March]

BALANCE CRITERIA
Aggregate Balance - <$200 - no discount applies

Aggregate balance – $201 to $999 - patient must complete a financial application for sliding scale discount or charity care. Presentation to PAC not required.

Aggregate balance - >$1000 – patient must complete a financial application for sliding scale discount. Case will be presented to PAC if the payment is unable to comply with payment arrangements on balance after discount.

INCOME/FAMILY SIZE <200% of FPIG
If income and family size place patient between zero and 200% of the FPIG, the patient will qualify for Uninsured Status and 100% discount. The patient should be directed to apply for city/state or other assistance programs before applying the discount.

INCOME/FAMILY SIZE >200% of FPIG, LEVEL 1 - 5
For qualifying patients, sliding scale will apply and patient may qualify for a minimum discount of 25% up to a maximum discount of 65%

INCOME/FAMILY SIZE IS BEYOND LEVEL 5
Patient will not qualify for a discount. Payment is expected.
SAMPLE LETTER

Date:________________________

Dear Patient:

APPROVAL:
Based on the information that you provided,
_______________% discount has been granted on your self pay balance/s.

DENIAL:
You are over income and do not qualify for a discount at this time

Prompt payment of your balance due is appreciated.

Please feel free to contact me if you have any questions.

Very truly yours,

Waterbury Hospital Health Center Patient Financial Services
CATEGORY: Credit & Collection Policies

POLICY: Uninsured Patient

PAGE: ORIGINATED: August 18, 2003


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.

Communication regarding the criteria will be printed on the back of all outgoing self pay statements [both at OSI and Vestcom] and will be handed to self pay patients in registration areas. 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 requests consideration for uninsured status. Per the attached flow chart, OSI will place the Encounter on hold after sending out the Uninsured letter and form.

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.

Patients meet definition of “uninsured”
- Cost will be calculated and an allowance will be processed.
- Patients can then be dunned for the balance [cost]

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.

To follow up on these Encounters, place statement suppression hold. The Encounters will be reflected on the Billing Entity Hold report and will be distributed by user. Send a follow up letter to the patient after two weeks if there has been no response from the patient.

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.

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 and returned to the hospital for determination. The Encounter will be transferred back to AR status.
If the patient qualifies, the balance will be reduced to cost and the Encounter will be returned to the agency for collection. The Encounter will be transferred back to BD status.

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
In Cerner, the following comments can be utilized:

- Uninsured Status Inquiry - Patient has requested to be reviewed for uninsured status. Information provided to patient re required documentation.

- Patient Granted UI Status - patient has provided all needed documentation and has met the criteria for uninsured status per the state of Ct. Balance is being adjusted to reflect cost. Notification sent to patient.

- Uninsured Status Denied - Patient did not meet the criteria:
  - Reason: [type reason here]

Recording Activity
An Access database has been created to track all applications for uninsured and free bed funding. The database is available on the Pashared drive N in folder Free Bed Funds, or by double-clicking on the special icon on your desktop.

Staff is expected to record all patients who wish to be considered for uninsured status as well as all applications for free bed funds. [see guidelines for data entry]

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

Annual Filing To OHCA [On Or Before March 1, 2004 And Annually Thereafter]

- 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.
SAMPLE LETTER

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 14 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
“UNINSURED PATIENT” CALCULATION FORM

FOR PATIENT FINANCIAL SERVICES USE ONLY:

Patient Name: ________________________________________________

Encounter # __________________________

APPROVED: COST TO CHARGE RATIO CALCULATION:

This Encounter has met the above criteria. Balance due from patient is as follows:

\[
\text{Total Charges} \times 0.35 = \text{Total Cost due from Patient}
\]

ALLOWANCE CALCULATION:

\[
\text{Total Charges} - \text{Total Cost due from patient} = \text{Cost to charge Allowance}
\]

DENIED:

This Encounter has not met the criteria set by the state of Connecticut to define an uninsured patient. Balance due from the patient is total charges:

\[
\text{Total Charges}
\]

*** FY03
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
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.

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

<table>
<thead>
<tr>
<th>UNINSURED PATIENT POLICY</th>
<th>SELF PAY DISCOUNT POLICY</th>
<th>CHARITY CARE POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has no insurance</td>
<td>Patient has no insurance</td>
<td>Balances in aggregate totaling &lt;$1000 and are………</td>
</tr>
<tr>
<td>Patient has been denied Medicaid/Saga</td>
<td>Patient’s income is above 200% poverty income guidelines</td>
<td>• Uncollectible Encounters</td>
</tr>
<tr>
<td>Patient’s income is at or below 200% of the poverty income guidelines.</td>
<td>Patient has a balance/s after insurance.</td>
<td>• Deceased, no estate</td>
</tr>
<tr>
<td>If these 3 criteria apply, patient qualifies as uninsured and balance is reduced to zero.</td>
<td>*Aggregate Balance - &lt;$200 - no discount applies</td>
<td>• Homeless, no information</td>
</tr>
<tr>
<td></td>
<td>*Aggregate balance – $201 to $999 - patient must complete a financial application for sliding scale discount or charity care. Presentation to PAC not required.</td>
<td>• Pt has recently been granted T19</td>
</tr>
<tr>
<td></td>
<td>*Aggregate balance - &gt;$1000 – patient must complete a financial application for sliding scale discount. Case will be presented to PAC if patient is unable to comply with payment arrangements on balance after discount.</td>
<td>--------------------------</td>
</tr>
</tbody>
</table>

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

Cost to Charge Alias – 2003 Refer to Cerner Free Bed transaction codes

Sliding Scale Alias – 2014 Prompt Pay Alias – 2013 Refer to Cerner Free Bed transaction codes

Charity Care Alias – 2010 Refer to Cerner Free Bed transaction codes
SECTION III: PATIENT STATEMENT POLICY & HANDBOOK
SCOPE: Dunning
PURPOSE: To Provide A Mechanism To Bill Patients Appropriately, Flag Encounters For Delinquency As Per Established Criteria, And Forward Unresolved Encounters To Collection Agencies.

POLICY: It is the policy of Waterbury Hospital To DUN Patients When Appropriate And To Handle Unresolved Encounters In A Consistent And Timely Manner.

Waterbury Hospital Health Center utilizes several means in order to properly dunn patients:
- Statement processing
- Outsourcing of Self-Pay to OSI
- Delinquency and referral to collection agency

Patients are dunned in accordance with contractual agreements and regulatory requirements as follows:
- Statements are generated for balances that are copays, deductibles and/or valid denials which are patient liable.
- Medicaid patients are not dunned.
- Valid workers compensation patients are not dunned.
- 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.”

As with all other patients who have insurance, Medicare patients do not receive a statement until the balance is in self pay.
WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES

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

1. Once the balance is in self pay, the encounter is referred to OSI.
2. If it has been greater than 90 days since the last final bill was generated and there is no payment activity, the balance is referred to OSI.

Once the balance is referred to OSI, 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.

BAD DEBT PROCESS:
Encounters are returned from OSI on a daily basis and referred immediately to collection agencies, also on a daily basis.

The collection agency follows the same collection processes for Medicare patients as they would for non-Medicare patients.

- Encounters are returned to the hospital after 12 months of collection inactivity.
- Medicare bad debts, which are deemed to be uncollectible, are reflected on the annual cost report.

Encounters with formal payment plans and/or in a manual dunning level, will flow thru the statement cycle and if unpaid or delinquent, will be placed in the Collection Preview queue for 10 days. After review, the encounter will be referred to collection.

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 flagged for Bad Debt, regardless of the age of the Encounter.
WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES

BALANCING:
[Separate balancing procedures are available]

MEDICARE BAD DEBTS
On an annual basis, unpaid Medicare deductibles and co-insurances are reported to Medicare via the Medicare Cost report as per the Medicare Bad Debt policy guidelines [separate procedures].

SMALL BALANCE WRITE-OFF:
Each day, debit and credit balances which qualify for small balance write-off, are automatically written-off. The current criteria for pending small balances for write-off are as follows:

- Small debit balances – Under $10.00
- Small credit balances – Under $5.00
### WATERBURY HOSPITAL
### CREDIT & COLLECTION POLICIES

**STATEMENT CYCLE MATRIX**

Special Rules:

<table>
<thead>
<tr>
<th>INITIAL CYCLE SET UP</th>
<th>CRITERIA</th>
<th>WHEN FIRST STATEMENT IS GENERATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers Compensation</td>
<td>Fin Class = Workers Compensation</td>
<td>Primary insurance is billed</td>
</tr>
<tr>
<td>Self Pay Cycle</td>
<td>Self Pay, Pending Medicaid/Saga</td>
<td>Self pay benefit order is ready to bill</td>
</tr>
<tr>
<td>Formal Payment Plan</td>
<td>Formal Plan = Yes</td>
<td>Self pay benefit order is ready to bill</td>
</tr>
<tr>
<td>Self Pay after Insurance</td>
<td>All Fin Classes</td>
<td>Self pay benefit order is ready to bill</td>
</tr>
<tr>
<td>Pending OSI</td>
<td><strong>Hold for 20 days after statement before qualifying for referral to OSI</strong></td>
<td><strong>Hold for 20 days after statement before qualifying for referral to OSI</strong></td>
</tr>
</tbody>
</table>
WATERBURY HOSPITAL  
CREDIT & COLLECTION POLICIES

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

<table>
<thead>
<tr>
<th>CYCLE</th>
<th>Dunning Level</th>
<th>ACCEPTABLE PAYMENT</th>
<th>UNACCEPTABLE PAYMENT</th>
<th>NO PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal Payment Plan Initial cycle</td>
<td>Normal 2</td>
<td>999 &gt; Formal Payment Plan</td>
<td>2 &gt; Final Demand</td>
<td>1 &gt; Final Demand</td>
</tr>
<tr>
<td>Workers Comp Initial cycle</td>
<td>Normal 1</td>
<td>3 &gt; Precollections</td>
<td>3 &gt; Workers Comp</td>
<td>3 – Workers Comp</td>
</tr>
<tr>
<td>Manual Statement Cycle</td>
<td>Normal 2</td>
<td>999 &gt; Manual Statement Cycle</td>
<td>2&gt; Final Demand *</td>
<td>2 &gt; Final Demand *</td>
</tr>
<tr>
<td>Encounters which are returned from OSI or which are not OSI but must receive statements.</td>
<td></td>
<td></td>
<td>* changed from 3 to 2 on 10-5-07</td>
<td>* changed from 3 to 2 on 10-5-07</td>
</tr>
<tr>
<td>Final Demand</td>
<td>Normal 2</td>
<td>999 &gt; Final Demand</td>
<td>1 &gt; Collections</td>
<td>1 &gt; Collections</td>
</tr>
<tr>
<td>Self Pay Cycle Initial Cycle</td>
<td>Normal 2</td>
<td>0 &gt; Precollections</td>
<td>0 &gt; Precollections OSI</td>
<td>0 &gt; Precollections OSI</td>
</tr>
<tr>
<td>Self Pay no insurance assigned to OSI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precollections Encounter is now OSI Precollections</td>
<td>Precollections 1</td>
<td>999 &gt; Precollections OSI</td>
<td>999 &gt; Precollections OSI</td>
<td>999 &gt; Precollections OSI</td>
</tr>
<tr>
<td>Self Pay after Insurance Pending OSI</td>
<td>Normal 2</td>
<td>0&gt;Precollections OSI</td>
<td>0&gt;Precollections OSI</td>
<td>0&gt;Precollections OSI</td>
</tr>
<tr>
<td>Collections</td>
<td>Collections 1</td>
<td>999 &gt; Collections</td>
<td>999 &gt; Collections</td>
<td>999 &gt; Collections</td>
</tr>
</tbody>
</table>
SECTION IV: BAD DEBT POLICIES

<table>
<thead>
<tr>
<th>CATEGORY: Credit &amp; Collection</th>
<th>POLICY: Collection Agency Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAGE:</td>
<td>ORIGINATED: 12/5/97</td>
</tr>
<tr>
<td>REVIEWED:</td>
<td>REVISED: Jul-03, Feb-04, Jan-07, Jan 2008</td>
</tr>
<tr>
<td>RETIRED:</td>
<td></td>
</tr>
</tbody>
</table>

SCOPE: Collection Agency referral

PURPOSE: To maximize cash flow by extending reasonable collection efforts on identified delinquent Encounters.

**POLICY:** To refer unpaid patient-due balances [deductibles, co-payments, co-insurances] to collection agencies for additional collection efforts.

**PROCEDURE:**
General guidelines regarding referral of overdue balances are listed below.

**THE INDIGENT OR MEDICALLY INDIGENT PATIENT**
Waterbury Hospital will refer uncollected patient charges to a collection agency unless it has been determined that the patient is uninsured, as per the state of Ct regulations governing free care. [PA 03-266]. Please refer to the Uninsured Patient Policy for details.

**DELINQUENCY**
There are two ways Encounters will be tagged for referral to a collection agency:
Via OSI as returned Encounters
Via the Manual or Formal Plan dunning process
In both instances, reasonable collection efforts have been exhausted.

**OUTSOURCED ENCOUNTERS**
Encounters returned from OSI with the following cancel codes, will be referred to collection agencies. Returns are received daily and referred out daily.

81 Close for Bad Debt
84 No address/no phone

**NON OUTSOURCED ENCOUNTERS**
Self-Pay Process
Encounters that have reached the end of the self-pay dunning process are placed in collection review for 10 days and then referred to collection agencies.

**RETURNED MAIL:**
The assumption is made that all statements, bills and letters reach the patient unless mail
WATERBURY HOSPITAL
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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 the age of the Encounter.

BAD DEBT PROCESS:
Please refer to the individual policy for the bad debt turnover and balancing process.

MEDICARE BAD DEBTS
On an annual basis, unpaid Medicare deductibles and co-insurances are reported to Medicare via the Medicare Cost report as per the Medicare Bad Debt policy guidelines [see Medicare Bad Debts policy].

REFERRAL/RECOVERIES/MAINTENANCE
• All Encounters returned from OSI Outsourcing with cancel codes specific to bad debt, will be identified by the cancel code.
• Non-Outsourced Encounters will be deemed “bad debt” via the delinquency pending process and bad debt transfer process.
• 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, predictive dialing, etc.
• Collection agencies will submit cases for approval by Manager, Customer Service, to be pursued for litigation.
• Payments made to Waterbury Hospital on bad debt Encounters will be reported to the collection agencies on a daily basis.
• Payments made directly to collection agencies will be reported to Waterbury Hospital on monthly remittances.
• All payments are gross and are posted directly to the patient Encounters on system.
• Contracted fees will be remitted back to the collection agencies via special check request, approved by director and processed by Encounters Payable.
• Encounters can be recalled at any time due to specific situations with approval of Manager and/or Director.
• 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.

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]

Encounters will not be reported to credit bureaus for routine collections, however, when an Encounter reaches legal status, it will be reported.

All efforts will be expended to collect all Encounters in full, however when faced with an offer of settlement, the following guidelines will apply:
All facts, including assets and liabilities of the patient must be supplied.
The attorney making the settlement request will supply all documentation regarding the
amount of the settlement.
Recommended settlement offers will be approved by the Assistant Director, PAFS based on the amount of the settlement and the balance due.

Steps taken prior to legal action:

- Patient is sent an initial notice identifying the collection agency and the balance currently due the Hospital.
- If there is no response to the initial notice, attempts are made to reach the patient by phone.
- A second letter is generated thirty-one days after the initial letter and there are continued attempts to reach the patient by phone.
- A third letter is generated fourteen days after the second.
- 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.
- 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.
- 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.
- 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. Normally, all attempts are made over a 90 to 120 day time period before considering this last course of action.

The Hospital and its collection agencies are careful to make sure that the debt is not disputed or that there is not an insurance issue with which we could resolve the balance due. Also, if a patient indicates that they are experiencing health or financial difficulties, they are referred for Free Bed Fund consideration and the application process is monitored prior to making any further attempts to collect the debt.

Collection agencies currently contracted with The Waterbury Hospital:

CONNECTICUT CREDIT
90 NATIONAL DRIVE, PO BOX 1264
GLASTONBURY, CT 06033-6264- (800) 221-0405

AMERICAN ADJUSTMENT BUREAU
PO BOX 2758/89 WILLOW ST.
WATERBURY, CT 06723- (203) 574-4200
COMPENSATION
The above collection agencies charge fees on a contingency basis. All monies collected by the agency 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.

UNCOLLECTIBLE ENCOUNTERS
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 uncollectibility which in most cases is one year [12 months] of no activity.

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.

REBILLING OF COLLECTION AGENCY ENCOUNTERS
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, however, Encounters must be billed or rebilled by the hospital due to electronic media and contracts. If this should occur, the following will apply:
Collection agencies will provide third-party billing requests in writing
All required billing data must be provided by the agency and forwarded to the hospital immediately.
After billing has taken place, the Encounters must be documented and the agency notified.
All requests for Itemized bills can be honored by both agencies since both have access to the hospital system in their offices.
Collection agency staff may also come on-site to pull remittances for additional billing.

Waterbury Hospital reserves the right to audit and physically inspect Encounters placed for collection with outside agencies.

Waterbury Hospital will maintain accurate records’ reflecting which collection agency has been assigned to each Encounter. Once Encounters are assigned, agencies must not be removed or changed unless by management for valid reason.
SCOPE: To comply with Medicare regulations concerning Bad Debts.

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.

POLICY: It is the policy of Waterbury Hospital Health Center to report all uncollected Medicare Bad Debt deductible and coinsurance amounts to Medicare on the Medicare Cost Report.

PROCEDURE:

When co-insurance and deductible balances are deemed to be uncollectible according to the Provider Reimbursement Manual, these balances can be reported back to Medicare via the annual cost report as follows:

On October 1\textsuperscript{st} of each year, a report is generated to reflect outstanding Medicare Encounters that were turned over to bad debt in the previous year. The Encounters are broken down by inpatient and outpatient categories. All Medicare bad debt Encounters are reviewed based on the following criteria:

- Verification that the balance is either patient deductible or co-insurance
- All adjustments were processed
- Has any portion of the balance been paid by the patient or another insurance carrier.
- 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. Follow the instructions below:

<table>
<thead>
<tr>
<th>Column</th>
<th>Column Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Provider Number</td>
<td>Patient’s Medicare number</td>
</tr>
<tr>
<td>II</td>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Date of Admission</td>
<td>Date service started</td>
</tr>
<tr>
<td>IV</td>
<td>Date of Discharge</td>
<td>Date service ended</td>
</tr>
<tr>
<td>V</td>
<td>Total covered</td>
<td>Total Part A hospital charges</td>
</tr>
<tr>
<td>VI</td>
<td>Patient Deductible Amount</td>
<td>Part A Deductible</td>
</tr>
<tr>
<td>VII</td>
<td>Patient Co insurance Amount</td>
<td>Part A Co insurance</td>
</tr>
<tr>
<td>VIII</td>
<td>Bad Debt amount claimed</td>
<td>The balance of the Part A hospital charges that are still outstanding</td>
</tr>
<tr>
<td>IX</td>
<td>Date of write off</td>
<td>Date Encounter was sent to bad debt</td>
</tr>
<tr>
<td>X</td>
<td>Medicare remittance date</td>
<td>The date of the remittance that the Empire Medicare payment was processed</td>
</tr>
</tbody>
</table>

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. A tape should also be taken of all bad debt amounts claimed.

The report, tape and schedule are maintained in the Patient Access / Financial Services Department until the next fiscal year.

**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.
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 Encounters and notes receivable which are created or acquired in providing services. "Encounters 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
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.

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,
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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 Encounter receivable, the full amount collected must be credited to the patient's Encounter 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 Encounter 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 Encounter 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 Encounter 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 Encounters receivable and notes receivable, the provider should have the usual Encounters receivable records-ledger cards and source documents to support its claim for a bad debt for each Encounter 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, Encounters receivable are analyzed and a determination made as to specific Encounters which are deemed uncollectible. The amounts deemed to be uncollectible are charged to an expense Encounter for uncollectible Encounters. The amounts charged to the expense Encounter 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 Encounter 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 Encounter. 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 Encounter.

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 Encounters 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.
SECTION V: EXHIBITS

THE FAIR DEBT COLLECTION PRACTICES ACT
As amended by Public Law 104-208, 110 Stat. 3009 (Sept. 30, 1996)

To amend the Consumer Credit Protection Act to prohibit abusive practices by debt collectors.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Consumer Credit Protection Act (15 U.S.C. 1601 et seq.) is amended by adding at the end thereof the following new title:
TITLE VIII - DEBT COLLECTION PRACTICES  [Fair Debt Collection Practices Act]

Sec.
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 practice
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. Effective date

§ 801. Short Title [15 USC 1601 note]
This title may be cited as the "Fair Debt Collection Practices Act."

§ 802. Congressional findings and declarations of purpose [15 USC 1692]
(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
直接影响州际贸易。
（e）本节的目的是消除滥用的债务收集实践，由债务收集人执行，以确保那些债务收集人不使用滥用的债务收集实践，与不使用滥用的债务收集实践的人在竞争上不处于不利地位，并且促进一致的州行动，以保护消费者免受债务收集滥用。

§ 803. 定义 [15 USC 1692a]
作为用于本节——
（1）术语"委员会"表示联邦贸易委员会。
（2）术语"交流"表示传达债务的信息，直接或间接地向任何个人通过任何媒介。
（3）术语"消费者"表示任何自然人，有义务或被认为有义务支付任何债务。
（4）术语"债权人"表示任何提供或提供信用，从而创造债务或其债务人，但该术语不包括任何个人，该个人在债务交割物中直接或间接地收到债务，目的是有助于收集该债务的另一种人的债务。
（5）术语"债务"表示消费者义务的任何义务或所谓的义务，这债务是从交易中产生的，该交易中的金钱、财产、保险或服务是该交易的主要目的，即为个人、家庭或家庭目的，不论该义务是否已经减少为判决。
（6）术语"债务人"表示任何使用任何州际贸易或邮递的工具的个人，以任何业务的主体目的，该业务的目的是收集任何债务，或定期收藏或尝试收集，直接或间接地，债务欠款或欠款或主张被欠款或欠款另一个。尽管第（F）段最后一句的排除，该术语包括任何债权人，当，以债权人之名，收集债务给债权人，使用任何其他名称，而不是他自己的名称，表示另一个第三个人正在收集或企图收集该债务。就第808 (6) 段的目的，该术语也包括任何使用任何州际贸易或邮递的工具的个人，以任何业务的主体目的，该业务的目的是执行财产利益。该术语不包括——
（A）任何债权人雇员，以债权人之名，收集债务给债权人；
（B）任何个人在另一个个人的债务收集人，两者，都是共同拥有或由公司控制，如果该个人作为债务收集人本身，则无需债务，但对于该个人的债务人，使用任何其他名称，而不是他自己的名称，表示另一个第三个人正在收集或企图收集该债务。就第808 (6) 段的目的，该术语也包括任何使用任何州际贸易或邮递的工具的个人，以任何业务的主体目的，该业务的目的是执行财产利益。该术语不包括——
（A）任何官员或雇员的债权人，以债权人之名，收集债务给债权人；
（B）任何个人在另一个个人的债务收集人，两者，都是共同拥有或由公司控制，如果该个人作为债务收集人本身，则无需债务，但对于该个人的债务人，使用任何其他名称，而不是他自己的名称，表示另一个第三个人正在收集或企图收集该债务。就第808 (6) 段的目的，该术语也包括任何使用任何州际贸易或邮递的工具的个人，以任何业务的主体目的，该业务的目的是执行财产利益。该术语不包括——
（A）任何官员或雇员的债权人，以债权人之名，收集债务给债权人；
（B）任何官员或雇员的债权人，以债权人之名，收集债务给债权人；
（B）任何官员或雇员的债权人，以债权人之名，收集债务给债权人；
（B）任何官员或雇员的债权人，以债权人之名，收集债务给债权人；
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  [15 USC 1692b]

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  [15 USC 1692c]

(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 [15 USC 1692d]

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) 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 [15 USC 1962e]

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.
(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 Encounters 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 [15 USC 1692f]
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:
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(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 purpose 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.

(7) Communicating with a consumer regarding a debt by postcard.

(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 [15 USC 1692g]

(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 creditor, 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.

(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.

§ 810. Multiple debts [15 USC 1692h]
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 [15 USC 1692i]
(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 [15 USC 1692j]
(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 [15 USC 1692k]
(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  [15 USC 1692]

(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, by the Comptroller of the Currency;

(B) member banks of the Federal Reserve System (other than national banks), by the Federal Reserve Board; and

(C) banks the deposits or Encounters of which are insured by the Federal Deposit Insurance Corporation (other than members of the Federal Reserve System), by the Board of Directors of the Federal Deposit Insurance Corporation;

(2) section 5(d) of the Home Owners Loan Act of 1933, section 407 of the National Housing Act, and sections 6(i) and 17 of the Federal Home Loan Bank Act, by the Federal Home Loan Bank Board (acting directing or through the Federal Savings and Loan Insurance Corporation), in the case of any institution subject to any of those provisions;
(3) the Federal Credit Union Act, by the Administrator of the National Credit Union Administration with respect to any Federal credit union;
(4) subtitle IV of Title 49, by the Interstate Commerce Commission with respect to any common carrier subject to such subtitle;
(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.
(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 [15 USC 1692m]
(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 [15 USC 1692n]
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 [15 USC 1692o]
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. Effective date [15 USC 1692 note]
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.
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Approved September 20, 1977

ENDNOTES
1. So in original; however, should read "604(a)(3)."

LEGISLATIVE HISTORY:
Public Law 95-109 [H.R. 5294]
HOUSE REPORT No. 95-131 (Comm. on Banking, Finance, and Urban Affairs).
SENATE REPORT No. 95-382 (Comm. on Banking, Housing, and Urban Affairs).
Apr. 4, considered and passed House.
Aug. 5, considered and passed Senate, amended.
Sept. 8, House agreed to Senate amendment.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 13, No. 39:
Sept. 20, Presidential statement.
AMENDMENTS:
SECTION 803, SUBSECTION (6), defining "debt collector," was amended to repeal the attorney at law exemption at former Section (6)(F) and to redesignate Section 803(6)(G) pursuant to Pub. L. 99-361, July 9, 1986, 100 Stat. 768. For legislative history, see H.R. 237, HOUSE REPORT No. 99-405 (Comm. on Banking, Finance and Urban Affairs).
SECTION 807, SUBSECTION (11), was amended to affect when debt collectors must state (a) that they are attempting to collect a debt and (b) that information obtained will be used for that purpose, pursuant to Pub. L. 104-208 § 2305, 110 Stat. 3009 (Sept. 30, 1996).
UCP Regulations

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 of an uninsured patient, multiplied by the hospital's most recent relationship of costs to charges as taken from the hospital's most recently available audited financial statements. (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 whose income is at or below two hundred percent of the poverty income guidelines who (A) has applied and been denied eligibility for any medical or health care coverage provided pursuant to sections 17b-19, 17b-22, 17b-63 to 17b-65, inclusive, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-103, inclusive, 17b-114 to 17b-138, inclusive, 17b-180 to 17b-183, inclusive, 17b-220 to 17b-250, inclusive, 17b-256, 17b-259 to 17b-287, inclusive, 17b-340 to 17b-350, inclusive, 17b-357 to 17b-362, inclusive, 17b-600 to 17b-604, inclusive, 17b-689 to 17b-693, inclusive, 17b-743 to 17b-747, inclusive, 17b-807 or 17b-808 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.

(P.A. 94-9, S. 36, 41; P.A. 95-257, S. 12, 21, 58.)

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.

Net revenue limit.

(a) For the fiscal year commencing October 1, 1994, and for subsequent fiscal years, the office shall establish an exempt authorized net revenue limit for each hospital provided, for the fiscal year commencing October 1, 1994, said limit shall be effective January 1,
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1995. Such limit shall be computed as follows: (1) For each hospital, except as described in subdivision (2) of this subsection, the hospital's authorized net revenue limit for the base year shall be multiplied by one plus the forecast of reasonable inflation determined in accordance with section 19a-678 less one percentage point; the result shall be adjusted for increases or decreases in equivalent discharges from the authorized base year using a fifty per cent variable cost adjustment factor. The exempt authorized net revenue for the budget year is determined by multiplying the budget year exempt authorized net revenue limit determined in accordance with this subdivision and subdivision (2) of this subsection by the rate year equivalent discharges projected pursuant to section 19a-679. (2) For the fiscal year commencing October 1, 1994, and the subsequent fiscal year, the base year authorization shall be adjusted to reflect the actual net revenue received by each hospital provided that this adjustment shall not be applied to increase the base above the authorized level. The adjustment shall be as follows: (A) For the fiscal year commencing October first, two years prior to the year for which authorization is being determined, the result of subdivision (2) of subsection (b) of section 19a-676 shall be divided by the result of subdivision (1) of subsection (b) of section 19a-676. If the result is greater than one, then it shall be replaced by one. (B) For the fiscal year commencing October 1, 1994, and the subsequent fiscal year, the result of subparagraph (A) of this subdivision, shall be multiplied by the hospital's authorized net revenue limit for the base year times one plus the forecast of reasonable inflation in accordance with section 19a-678 less one percentage point; the result shall be adjusted for increases or decreases in equivalent discharges from the authorized base year using a fifty per cent variable cost adjustment factor. (b) Equivalent discharges shall be computed in accordance with section 19a-679. (c) Each hospital regardless of whether its budget is authorized through the exempt, partial or detailed budget review process shall file with the office copies of all its Medicare cost reports and, on or before June first annually, shall file any other information deemed necessary by the office for purposes of this section and sections 19a-670 to 19a-672, inclusive. (d) Each hospital regardless of whether its budget is authorized through the exempt, partial or detailed budget review process shall also file with the office by October first of each fiscal year, or a later date specified by the office, its rates or charges. Said filing shall be for informational purposes only. (e) On or before July first annually, the office shall set the limit described in this section for each hospital, except as such limit is modified in accordance with sections 19a-674 to 19a-676, inclusive. (f) Each hospital shall submit a budget request annually under this section.

(P.A. 94-9, S. 27, 41; P.A. 95-160, S. 58, 69; 95-257, S. 39, 58; P.A. 96-139, S. 12, 13.) History: P.A. 94-9 effective April 1, 1994; P.A. 95-160 amended Subdiv. (2) of Subsec. (a) to add application to fiscal years subsequent to October 1, 1994, and make technical conforming changes, 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; Sec. 19a-170a transferred to Sec. 19a-674 in 1997.

Sec. 19a-675. (Formerly Sec. 19a-170b). Filings for partial or detailed budget review.
Hearings. (a) If a hospital qualifies to receive greater revenue than would be allowed under the limit described in section 19a-674, it may file for partial or detailed budget review under this section by July first of the base year or such later date as the office may specify. (b) A hospital shall be entitled to request partial budget review if it is able to attribute the need for generating revenue greater than such limit to incremental costs associated with certificate of need projects approved under the provisions of sections 19a-638 and 19a-639 for the rate year provided such request is consistent with the office's decision authorizing the project and the certificate of need was approved prior to May first of the base year. Such request shall be made in the form and manner prescribed by the office. The office shall review the information submitted by the hospital and shall approve, modify or deny the request. If the office approves or modifies the request, the net revenue limit shall be computed in the manner specified in subsection (a) of section 19a-674, except that approved incremental costs attributable to an approved certificate of need project or projects shall be included in net revenue and approved incremental volume shall be included in the determination of equivalent discharges. (c) If a hospital is unable to attribute the need for generating revenue greater than such limit to an authorized certificate of need project it may elect to undergo detailed budget review in accordance with this subsection provided its cost index calculated pursuant to section 19a-677 is less than 0.95 and provided the requested net revenue limit is less than the limit calculated pursuant to subsection (c) of section 19a-677. Such hospital shall submit a detailed budget projection as to its anticipated expenses and projected net revenue requirement to provide for such expenses. The office may require the hospital to submit such information, data, records, studies and evaluations as it considers necessary to determine the need for generating greater net revenue. Submissions made pursuant to this subsection shall be in the form and manner prescribed by the office. The hospital shall bear the burden of demonstrating to the office that the components of its proposed budget are reasonable. The components shall include, but are not limited to: Expenses, incremental volume associated with an approved certificate of need project, if any, operating gain and net revenue. After review of the hospital's filing, the office may issue a proposed final decision regarding the hospital's request. Within ten calendar days of receipt of the proposed final decision, the hospital may request a hearing on its proposed budget. A request for a hearing shall include all evidence the hospital is requesting be included in the record for the hearing. The office shall schedule a public hearing on the proposed final budget within thirty days of its receipt of the required submissions. Any such hearing shall be conducted in accordance with subsection (c) of section 19a-167c. In determining the authorized net revenue limit, the office may modify any budget component which it deems is not fully justified by the hospital. If the office approves or modifies the request, the authorized net revenue limit shall be computed as the net revenue determined to be appropriate by the office, divided by the equivalent discharges determined pursuant to section 19a-679 including any approved adjustments to equivalent discharges attributable to an approved certificate of need project or projects.

(P.A. 94-9, S. 28, 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-170b transferred to Sec. 19a-675 in 1997.
(a) 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 to implement this section. For the period January 1, 1995, through September 30, 1995, and for subsequent fiscal years, if a hospital exceeds its authorized net revenue limit, adjusted for changes in equivalent discharges and for unbundling of services, an amount equal to the excess revenue for the year prior to the base year as determined in subdivision (3) of subsection (b) of this section shall be (1) deducted from the subsequent fiscal year's net revenue limit; (2) paid by the hospital to the office in four equal instalments commencing October first of the year two years following the year for which the compliance is being determined and deposited into the General Fund; or (3) deducted from payments to hospitals from the Medicaid Encounter, as determined by the Department of Social Services, in consultation with the Office of Policy and Management. (b) For the period January 1, 1995, through September 30, 1995, and for subsequent fiscal years, the excess revenue for the fiscal year shall be calculated as provided in subdivisions (1) to (3), inclusive, of this subsection, except that for the fiscal year commencing October 1, 1994, only, the compliance amount shall be calculated at a rate of 0.75 times the computed compliance amount for the period from October 1, 1994, to September 30, 1995, inclusive. (1) The office shall adjust the compliance adjusted authorized net revenue of the hospital for the difference between the equivalent discharges used in determining authorized net revenue and the equivalent discharges experienced by the hospital in the budget year using a fifty per cent variable cost factor. The result shall be the volume adjusted net revenue. (2) The office shall adjust the actual net revenue of the hospital, including net payments from the uncompensated care pool and payments from the Department of Social Services, then adjusting for any unbundling of services. If the actual uncompensated care rate experienced by the hospital exceeds the authorized uncompensated care rate, the difference times the total actual charges shall be added to the actual net revenue plus unbundling adjustments. The result shall be the adjusted actual net revenue. (3) The net revenue compliance adjustment shall be the adjusted net revenue calculated in subdivision (2) of this subsection minus the adjusted authorized net revenue calculated in subdivision (1) of this subsection. If this compliance adjustment is positive, that is, if the hospital collected more revenue than authorized, the amount shall be increased by the percentage increase in the authorized net revenue per equivalent discharge between the year for which the compliance adjustment is being calculated and the year in which the adjustment is being applied. This amount is called the inflation adjusted net revenue compliance adjustment. This amount shall be (A) deducted from the subsequent fiscal year's net revenue limit; (B) paid by the hospital to the office in four equal instalments commencing October first of the year two years
following the year for which the compliance is being determined and deposited into the General Fund; or deducted from payments to hospitals from the Medicaid Encounter, as determined by the Department of Social Services, in consultation with the Office of Policy and Management. Notwithstanding the requirements of this subsection, for the fiscal year commencing October 1, 1995, compliance payments shall not be required to be made on an equal quarterly basis. (c) By April thirtieth of each year each hospital shall calculate its compliance adjustment based on the data for the first six months of the hospital fiscal year and report this calculation to the office in the form and manner prescribed by the office. If such data shows that the hospital is not in compliance, the hospital shall implement and provide to the office by April thirtieth of the same year a plan of correction in order to comply with the authorized net revenue limit. (d) Any compliance calculated pursuant to this section shall not be affected by the termination of the hospital budget review pursuant to sections 19a-167 to 19a-167d, inclusive, of the general statutes, revision of 1958, revised to 1993, as amended, and the repeal of said sections shall not affect any liability or obligation imposed pursuant to this section.


*Note: On and after October 1, 1997, this section, as amended by section 1 of public act 96-238, is to read as follows: "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 Encounter; (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
(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 Encounter 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.

For the fiscal year commencing October 1, 1994, and for subsequent fiscal years, the Office of Health Care Access shall use the inflation factor as specified in section 19a-167g-61 of the regulations of Connecticut state agencies, as from time to time amended, except that the inflation proxy for salaries and wages shall be the Employment Cost Index for Wages and Salaries, All Private Service Industry Workers, Northeast. (P.A. 94-9, S. 31, 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-170e transferred to Sec. 19a-678 in 1997.
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.

Net revenue limit interim adjustment.

Notwithstanding any provision of the general statutes or regulations adopted thereunder, a hospital shall be entitled to receive a net revenue limit increase by means of an interim adjustment, only if it has a cost index calculated pursuant to section 19a-677 of less than 0.9, and the percentage increase in authorized net revenue shall be no greater than one minus the cost index of the hospital.

(1) "Certified health plan" means a plan that provides the standard benefits package and meets the requirements established by the Office of Health Care Access; (2) "Office" means the Office of Health Care Access; (3) "Standard benefits package" means the specified set of health services, as determined by federal law or in the absence of such applicable federal law, as determined by state law, that are the minimum which must be available from each certified health plan; (4) "Health care provider" or "provider" means a state licensed or certified person or state-authorized facility, which delivers diagnostic, treatment, inpatient or ambulatory health care services; (5) "Health plan" means any hospital or medical policy or certificate or contract, hospital or medical service plan contract, or health care center contract. The term does not include accident-only, specific disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance; (6) "Institute" means the Connecticut Health Care Data Institute established pursuant to section 19a-616 and operated by The University of Connecticut Health Center.
Definition of Family

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.
FINANCIAL ASSISTANCE APPLICATION FORM

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: _______________________________
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 live in household, including spouse]

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Birth Date</th>
<th>SSN #</th>
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<tbody>
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</table>

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__________
INCOME FROM OTHER SOURCES:  spouse ____dependent___ other___

Employer name____________________________________phone #________________

Address

Dates of employment: from ________________________ to ___________________

Gross weekly income __________________ net weekly income ______________

MISCELLANEOUS INCOME

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Amount of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent</td>
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<tr>
<td>Pensions</td>
<td></td>
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<tr>
<td>Social Security [SSN]</td>
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<tr>
<td>Veterans’ Security</td>
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<tr>
<td>Workman’s compensation</td>
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<tr>
<td>Unemployment compensation</td>
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<tr>
<td>Other:</td>
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<td>Other:</td>
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</table>

Total from All Income Sources     $__________

PERSONAL / CAPITAL ASSETS

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<thead>
<tr>
<th>Personal Asset</th>
<th>Amount of asset</th>
<th>Capital Asset</th>
<th>Purchase Date</th>
<th>Price</th>
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</thead>
<tbody>
<tr>
<td>Checking accounts</td>
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<td>Real Estate [own home]</td>
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</tr>
<tr>
<td>Savings accounts</td>
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<td>Automobile</td>
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<tr>
<td>Life Insurance [cash surrender value]</td>
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<td>Other:</td>
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<td>Securities and bonds</td>
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<td>Other:</td>
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<tr>
<td>Total personal</td>
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<td>Total Capital</td>
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</table>

Income Tax Refund (s) Federal $ State $
### V. CURRENT DEBTS

<table>
<thead>
<tr>
<th>Type of Debt</th>
<th>To Whom Paid</th>
<th>Monthly Payment</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgage</td>
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<td>Rent</td>
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<td>Gas</td>
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<td>Electric</td>
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<td>Phone</td>
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<td>Oil</td>
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<tr>
<td>Income taxes due IRS</td>
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<td>Finance Companies</td>
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<td>Credit Unions</td>
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<tr>
<td>Life Insurance</td>
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<tr>
<td>Homeowner/Rental</td>
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<tr>
<td>Insurance</td>
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<td>Car Insurance</td>
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<tr>
<td>Property Tax</td>
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<td>Other</td>
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### CHARGE ACCOUNTS

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<thead>
<tr>
<th>Credit card/Store</th>
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<th>Balance</th>
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### OTHER MEDICAL BILLS

<table>
<thead>
<tr>
<th>Hospital/Doctor etc.</th>
<th>Monthly Payment</th>
<th>Balance</th>
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<tbody>
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</tr>
</tbody>
</table>

Total outstanding debts $______________________________
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
WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES

*IMPORTANT INFORMATION FOR PATIENTS WITH NO INSURANCE COVERAGE.*

According to the state of Connecticut Public SB 568, you may qualify to be billed at cost for your services at Waterbury Hospital Health providing you meet the full criteria that the state of Connecticut has set forth to define an "uninsured patient". Criteria is as follows:

1. Patient has applied and been denied eligibility of any medical or healthcare coverage provided by the state of Connecticut i.e. Medicaid or City Welfare, due to failure to satisfy income or other eligibility requirements…[DENIALS MUST BE VALID and proof of denial is required] AND

2. Patient is **not eligible** for coverage of hospital services under the Medicare or Champus programs, or under Medicaid or health insurance program of any other state, country or 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…AND

3. Income Level must be at or below **250%** of the most recent Poverty Income Guidelines.
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.”
WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES

Statement Cycle Tool

Statement Level Messages

Cyclic Definition

Cycle Name: Final Demand
Dunning Level: Normal # 2
Bill Type: Patient Statement

Bill every: 30 days.

Initial Cycle Setup

Path Flow

Initial Cycle Message
First message for this cycle: We have not received payment
We have not received payment. Payment in full is expected. Please contact our office, at 203-573-7116

Dunning Messages

Acceptable payment: Thank you for your recent payment. Thank you for your recent payment. Please direct any inquiries to 203-573-7116.
Payment received: FAILURE for encounter: 
Payment received: unacceptable for encounter: 
Unacceptable payment: Thank you for your recent payment. However, it does not meet our minimum guidelines. Please call Patient
No payment: We have not yet received payment
We have not yet received payment. Please contact our office, at 203-573-7116 to prevent further
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
CREDIT & COLLECTION POLICIES

Statement Cycle Tool

Cycle Definition

- Cycle Name: Worker's Compensation
- Dunning Level: Normal #1
- Bill Type: Patient Statement

Initial Cycle Setup

- Bill every: 1 days

Path Flow

Initial Cycle Message

First message for this cycle:

Please provide us with verification from your employer that this is a valid Worker's Compensation claim. We

Dunning Messages

- Acceptable payment: We have received payment...
- Payment received: unacceptable for encounter: <<Nothing>>
- Unacceptable payment: We have not yet received full payment from your insurance carrier(s)
- No payment: We have not yet received full payment from your insurance carrier(s)

Save Cancel
### Statement Cycle Tool

**Cycle Definition**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cycle Name</td>
<td>Precollections</td>
</tr>
<tr>
<td>Dunning Level</td>
<td>Pre-Collections #1</td>
</tr>
<tr>
<td>Bill Type</td>
<td>Patient Statement</td>
</tr>
<tr>
<td>Bill every</td>
<td>1 day(s)</td>
</tr>
</tbody>
</table>

**Initial Cycle Message**

- First message for this cycle: 
  - Acceptable payment: 
  - Payment received: 
  - Unacceptable payment: 
  - No payment: 

**Path Flow**

- Save
- Cancel
WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES

Statement Cycle Tool

Initial Cycle Setup

Rule Properties

Available Criteria

Select Criteria

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: 12/31/2000

Save  Cancel
WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES

Statement Cycle Tool

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 Plan
- Insurance Organization
- Person VIP

Selected Criteria:
- Name
- Financial Class

Select Financial Class
- Selected Values:
  - Blue Cross
  - Blue Cross HMO
  - Blue Cross PPO
  - Commercial Insurance
  - Commercial PPO
  - Commercial FSA
  - Managed Medicaid
  - Managed Medicare
  - Medicare
  - SAGA
  - Commercial HM0

Rule Result Properties:
- Statement Cycle Name: Sell Pay After Insurance Pending CSI
- Statement Cycle Start: Sell pay benefit order is ready to bill
- Beginning Effective Date: 09/16/2005
- Ending Effective Date: 09/16/2015

Save | Cancel
## PATH FLOWS

**Table: Path Definition for Waterbury Health System**

<table>
<thead>
<tr>
<th>Current Cycle</th>
<th>Next Cycle</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final Demand</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptable</td>
<td>Final Demand</td>
<td>999</td>
</tr>
<tr>
<td>Unacceptable</td>
<td>Collections</td>
<td>0</td>
</tr>
<tr>
<td>No Payment</td>
<td>Collections</td>
<td>0</td>
</tr>
<tr>
<td>Collections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptable</td>
<td>Collections</td>
<td>999</td>
</tr>
<tr>
<td>Unacceptable</td>
<td>Collections</td>
<td>999</td>
</tr>
<tr>
<td>No Payment</td>
<td>Collections</td>
<td>999</td>
</tr>
<tr>
<td>Formal Payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptable</td>
<td>Formal Payment Pl...</td>
<td>999</td>
</tr>
<tr>
<td>Unacceptable</td>
<td>Final Demand</td>
<td>2</td>
</tr>
<tr>
<td>No Payment</td>
<td>Final Demand</td>
<td>0</td>
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<tr>
<td>Worker's Compensation</td>
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<td></td>
</tr>
<tr>
<td>Acceptable</td>
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<td>3</td>
</tr>
<tr>
<td>Unacceptable</td>
<td>Worker's Compensation</td>
<td>999</td>
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<tr>
<td>No Payment</td>
<td>Worker's Compensation</td>
<td>999</td>
</tr>
<tr>
<td>Precollections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptable</td>
<td>Precollections</td>
<td>999</td>
</tr>
<tr>
<td>Unacceptable</td>
<td>Precollections</td>
<td>999</td>
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<tr>
<td>No Payment</td>
<td>Precollections</td>
<td>999</td>
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<tr>
<td>Self Pay Cycle</td>
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<tr>
<td>Acceptable</td>
<td>Precollections</td>
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<td>Unacceptable</td>
<td>Precollections</td>
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<tr>
<td>No Payment</td>
<td>Precollections</td>
<td>0</td>
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<tr>
<td>Manual Statement</td>
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<tr>
<td>Acceptable</td>
<td>Manual Statement</td>
<td>399</td>
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<tr>
<td>Unacceptable</td>
<td>Final Demand</td>
<td>2</td>
</tr>
<tr>
<td>No Payment</td>
<td>Final Demand</td>
<td></td>
</tr>
</tbody>
</table>

*** 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.

When a formal plan is set up the following messages
**FORMAL PLAN MESSAGES**

<table>
<thead>
<tr>
<th>Message Type</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Set Up Message</strong></td>
<td>You have entered into a formal payment plan with Waterbury Hospital. Please make your monthly payment.</td>
</tr>
<tr>
<td><strong>Acceptable Payment Message</strong></td>
<td>The patient pays the installment amount within the established timeframe. Thank you for your recent payment. Please continue to honor your payment plan.</td>
</tr>
<tr>
<td><strong>Unacceptable Message</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>No Payment Message</strong></td>
<td>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.</td>
</tr>
</tbody>
</table>

**MANUAL STATEMENT CYCLE MESSAGES**

<table>
<thead>
<tr>
<th>Message Type</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Set Up Message</strong></td>
<td>This account has been reviewed and it has been determined that the balance is due from the patient.</td>
</tr>
<tr>
<td><strong>Acceptable Payment Message</strong></td>
<td>The patient makes payment within the established timeframe. Thank you for your recent payment. Please direct any inquiries to 203-573-7116.</td>
</tr>
<tr>
<td><strong>Unacceptable Message</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>No Payment Message</strong></td>
<td>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.</td>
</tr>
<tr>
<td>FINAL DEMAND</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WATERBURY HOSPITAL
CREDIT & COLLECTION POLICIES
FINIAL DEMAND MESSAGES

Initial Set Up Message
This will be on the first statement sent after the statement cycle drops to Final Demand.

Acceptable Payment Message
The patient pays the installment amount within the established timeframe.

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.

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 received payment. Payment in full is expected. Please contact our office, at 203-573-7116 at your earliest convenience. Thank you. **

Thank you for your recent payment. Please direct any inquiries to 2035737116.

Thank you for your recent payment, however, it does not meet our minimum guidelines. Please call Patient.

We have not yet received payment. Please contact our office, at 203-573-7116 to prevent further collection efforts. Thank you. **

Once the statement cycle changes to collection and the statements stop, the encounter will drop into the collection preview queue.

** Messages changed 9-26-07

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.

<table>
<thead>
<tr>
<th>Account #</th>
<th>Amount Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>190329</td>
<td>1364.65</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statement Date</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>07-29-2007</td>
<td>08-28-2007</td>
</tr>
</tbody>
</table>
FINANCIAL ASSISTANCE APPLICATION FORM 2008

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: ____________________________________________
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 live in household, including spouse]

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Birth Date</th>
<th>SSN #</th>
</tr>
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<tbody>
<tr>
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</table>

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 ____________
INCOME FROM OTHER SOURCES: spouse ___ dependent ___ other ___

Employer name____________________________________ phone # __________________

Address

________________________________________________________________________

Dates of employment: from ________________________ to ______________________

Gross weekly income __________________ net weekly income __________________

MISCELLANEOUS INCOME

<table>
<thead>
<tr>
<th>Source of Income</th>
<th>Amount of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent</td>
<td></td>
</tr>
<tr>
<td>Pensions</td>
<td></td>
</tr>
<tr>
<td>Social Security [SSN]</td>
<td></td>
</tr>
<tr>
<td>Veterans’ Security</td>
<td></td>
</tr>
<tr>
<td>Workman’s compensation</td>
<td></td>
</tr>
<tr>
<td>Unemployment compensation</td>
<td></td>
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<tr>
<td>Other :</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

Total from All Income Sources $ __________________

PERSONAL / CAPITAL ASSETS

<table>
<thead>
<tr>
<th>Personal Asset</th>
<th>Amount of asset</th>
<th>Capital Asset</th>
<th>Purchase Date</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checking accounts</td>
<td></td>
<td>Real Estate [own home]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Savings accounts</td>
<td></td>
<td>Automobile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Insurance [cash surrender value]</td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Securities and bonds</td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total personal</td>
<td></td>
<td>Total Capital</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Income Tax Refund (s)

<table>
<thead>
<tr>
<th>Federal $ State $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
### V. CURRENT DEBTS

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

### CHARGE ACCOUNTS

<table>
<thead>
<tr>
<th>Credit card/Store</th>
<th>Monthly Payment</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
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</tr>
</tbody>
</table>

### OTHER MEDICAL BILLS

<table>
<thead>
<tr>
<th>Hospital/Doctor etc.</th>
<th>Monthly Payment</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>2009 - 2010 Federal Poverty Income Guidelines</th>
<th>100%</th>
<th>200%</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,830</td>
<td>100%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>$14,750</td>
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<td>$22,050</td>
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<td>$25,790</td>
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<td>$29,530</td>
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<tr>
<td>$33,270</td>
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<td>$37,010</td>
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</tbody>
</table>

For each additional family member add $7,480