



**Legacy Western Connecticut Health Network  
FINANCIAL POLICY  
CREDIT AND COLLECTION**

**I. GENERAL**

- A. Confirmation of Payment Source. To ensure adequate reimbursement to meet operating needs, WCHN (the “Western Connecticut Health Network”) requires payment or proof of the ability to pay at or before the time of service. Consistent with its charitable mission, however, the Network will not deny medically necessary care because of a lack of financial information or financial resources. The Network may delay or deny elective care if financial resources are not properly identified.
- B. Referral for Collection. In general, it is the Network’s policy that accounts not paid within ninety (90) days will be reviewed for appropriate collection action. However, no account will be sent to collection until reasonable efforts have been undertaken to determine whether the patient is eligible for free or discounted care pursuant to the Network’s Financial Assistance Policy.
- C. Write-Off of Uncollectible Accounts. No later than sixty (60) days after review, accounts deemed uncollectible will be written-off.
- D. Terminology. For purposes of this Policy, the term “patient” is used with regard to the patient or the applicable payment source for the patient’s care (*e.g.*, parent, guardian or other responsible party).

**II. ASSIGNMENT OF BENEFITS**

- A. Medicare – With proper identification, the Network will accept Medicare assignment for covered services. Deductibles and co-pays are due in accordance with federal regulations. Non-covered services, with proper notification, are payable at the time of service or billing. The Network recognizes its responsibility to provide notice of non-coverage.
- B. Contracted Payors (*e.g.*, Blue Cross) – With proper identification, the Network will accept payor assignment for covered services. Deductibles and co-pays are due in accordance with the relevant payor agreement then in force. Non-covered services, with proper notification, are payable at the time of service or billing. The Network recognizes its responsibility to provide notice of non-coverage.
- C. Medicaid – With proper identification, the Network will accept Medicaid assignment for covered services.
- D. Other Third-Party Coverage – With proper identification, the Network will, as a courtesy, bill other non-contracted third-party payors. Since the Network does not



have a contractual relationship with these payors, the Network considers the patient ultimately responsible for payment. The Network will wait a maximum of sixty (60) days from initial billing for third-party payment; thereafter, any outstanding balance immediately becomes a patient responsibility. After one hundred twenty (120) days, all outstanding balances are immediately due from the patient. The Network may, in its discretion, wait another thirty (30) days if the patient and/or third-party payor shows a good faith effort to expedite payment.

- E. Self-Pay Obligations – As noted above, the Network will not deny necessary care because of a lack of financial resources. However, self-pay obligations are payable at the time of service or billing. The Network will assist a patient in obtaining available third-party coverage. Additionally, the Network will provide a credit review to determine if extended credit terms are warranted. In all cases, self-pay patients will be informed of the availability of free or discounted care pursuant to the Network’s Financial Assistance Policy. In connection with its services to uninsured patients, the Network will at all times abide by applicable provisions of federal and state law, including without limitation as set forth in the Network’s Financial Assistance Policy.

### **III. DELAY/DENIAL OF CARE**

- A. Conditions for Delay/Denial of Care. The Network will not delay or deny medically necessary care because of a lack of financial information or financial resources. However, the Network may delay or deny elective care if financial resources are not properly identified.
  - 1. Inpatient and One Day Surgical Admissions – The patient, admitting physician, chief of service and the operating room (if necessary) will be notified as soon as possible of any admission delayed or denied for financial reasons.
  - 2. Outpatient – The patient, the department requested to provide service, and the referring physician will be notified as soon as possible of any treatment or services delayed or denied for financial reasons.
- B. Determination of Medical Necessity. Issues regarding determination of medical necessity will be resolved between the attending (referring) physician and the chief of service.

### **IV. ADMINISTRATION OF POLICY**

The Network’s Business Office will administer and implement this Policy and will assume the following responsibilities:

- A. Undertaking credit analysis to assess patients’ ability to pay;



- B. Ensuring that patients are aware of the availability of free or discounted care pursuant to the Network's Financial Assistance Policy and, as appropriate, assisting patients in preparing the appropriate application and supporting materials;
- C. Providing additional guidance and assistance to patients through trained financial counselors;
- D. Collaboratively working with patients to establish payment arrangements that are fair, equitable, and realistic in light of each patient's available financial resources;
- E. Following up with patients or payors regarding the status of delayed or delinquent payments;
- F. Recommending write-offs for accounts deemed to be uncollectible;
- G. Recommending referrals to outside collection agencies, where appropriate; and
- H. Recommending collection litigation in appropriate circumstances, after consultation with the Network's legal counsel.

**V. COLLECTION**

WCHN's standard billing cycle is one hundred twenty (120) days from the date of the first guarantor billing statement.

- A. Measures Prior to Collection Agency Referral. Prior to referring any patient account to an external collection agency or initiating any legal action against an individual patient (or the patient's estate), the Network will take reasonable measures to confirm both of the following:
  - 1. That no alternative payment sources exist (whether through insurance, governmental programs, or family or other parties having legal responsibility for payment), or that all alternative payment sources have been exhausted; and
  - 2. That the Network has provided the patient with at least four (4) separate written communications specifically stating the following:
    - Whether the Network deems the patient an insured patient or uninsured patient, and the reasons for each such determination;
    - That the patient may qualify for free or discounted care pursuant to the Network's Financial Assistance Policy, with reasonable instructions regarding the process for applying thereunder; and



- That the Network is willing to work with the patient in establishing payment arrangements that are fair, equitable and realistic in light of the patient's available financial resources.
3. Payment agreements are available for patients who need longer than 120 days to pay off their balance. Submitting partial payments during the 120 day cycle without entering into a payment agreement does not constitute as an arrangement, however the good faith payment will be applied to the outstanding balance.
  4. Accounts that are not paid in full or on an approved payment arrangement will be returned at 120 days and may be referred to a collection agency or attorney.
  5. WCHN may forward balances to a collection agency or attorney if:
    - Guarantor has not paid the patient balance within 120 days following first guarantor billing statement.
    - Guarantor is not meeting terms of approved payment agreement
      - After 1 (one) default payment in a payment agreement. (A default payment is defined as a late or missed payment or a shortage of the agreed upon amount at any point during the payment agreement)
  6. Should USPS return Network written correspondence due to an incorrect address, if a correct address cannot be located the statement accounts are subject to collection referral prior to the 120 day billing cycle.
- B. Permissible Collection Agencies. The Network may refer patient accounts to one or more established, reputable debt collection agencies or attorney, provided that each such agency or attorney has provided the Network with written confirmation that such agency:
1. Will utilize only those collection techniques specifically permitted by the Network, whether pursuant to this Policy or otherwise;
  2. Will not utilize any collection techniques specifically prohibited by the Network pursuant to this Policy; and
  3. Will otherwise abide by applicable federal and state law.



The Network will not refer any patient account to a collection agency that has failed to provide the foregoing written confirmation. In addition, the Network will immediately terminate its relationship with any agency that has provided such a confirmation but fails to adhere thereto.

C. Collection Techniques.

1. Network to Specify. The Network will specifically instruct (whether by providing a copy of this Policy or otherwise) every collection agency it retains regarding debt collection techniques that are expressly permitted, and those that are expressly prohibited, in pursuing collection of patient accounts on behalf of the Network.
2. Permitted Collection Techniques. Permitted collection techniques include:
  - Telephone calls
  - Written correspondence
  - Skip tracing
  - Wage garnishment
  - Liens on assets (including but not limited to primary residences)
  - Small claims or other legal actions (the Network will not pursue guarantor accumulative balances under \$5,000.00)
  - Other techniques permitted by law and not expressly prohibited below
3. Required Written Statements. In at least two of its written communications with patients, the agency must specifically state the following:
  - Whether the Network deems the patient an insured patient or uninsured patient, and the reasons for each such determination;
  - That the patient may qualify for free or discounted care pursuant to the Network's Financial Assistance Policy, with reasonable instructions regarding the process for applying thereunder; and
  - That the Network is willing to work with the patient in establishing payment arrangements that are fair, equitable and realistic in light of the patient's available financial resources.
4. Prohibited Collection Techniques. A collection agency or attorney working on behalf of the Network may not do any of the following:
  - Harass, oppress or abuse any person;
  - Threaten to have the patient arrested for non-payment of debts;



- Falsely imply that they are attorneys or government representatives;
- Falsely imply that the patient has committed a crime;
- Falsely state that they operate or work for a credit bureau;
- Misstate the amount of the patient's debt;
- Misrepresent the involvement of an attorney in connection with collecting amounts owed;
- Indicate (i) that papers being sent are legal forms when they are not, or (ii) that papers being sent are not legal forms when they are;
- Threaten any collection action or measure not permitted by law;
- Provide false credit information about the patient to a third party;
- Use a false name; or
- Use any other collection methods prohibited by law.

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