**DMH POLICY**

| **Charges for Care (Interim)** | **Policy # 98-1**<br>**Date Issued:** December 30, 1997<br>**Effective Date:** January 1, 1998 |
|---|---|
| **Approval by Commissioner**<br>**Signed by:** Marylou Sudders | **Date:** December 30, 1997 |

## I. AUTHORITY

M.G.L. c. 19 and c. 123 s. 32 and 104 CMR 30.04 (6) and (7) allow for the assessment of Charges for care and treatment and require the Department to promulgate policies regarding the adjustment of those Charges for care and treatment not covered by any contract of insurance or entitlement.

## II. PURPOSE

To establish interim rules governing the process by which a Patient has Charges for care assessed or adjusted. This process will include: Charge notification; insurance inquiry; financial ability determination; adjustment calculation; adjusted Charge notification, and appeals of adjusted Charges. This policy repeals DMH Policy #86-4.

## III. SCOPE

This interim policy is applicable to all Department-operated Facilities with the exception of those psychiatric units within public health hospitals. This interim policy replaces the former 104 CMR 2.15 which was repealed effective January 1, 1998.

## IV. POLICY

Charges for care or treatment not covered by any contract of insurance or entitlement, shall be assessed to the individual Patient, provided that the Department shall make adjustments to such Charges based on the type of service provided, the Patient's individual financial circumstance, and the Patient's ability to pay.

## V. DEFINITIONS

**Approved Rate -** the Charge for a service which is established by the Department and approved by the Division of Health Care Finance and Policy or other rate approving authority.

**Charge -** the dollar amount assessed for care or treatment by a Facility as filed with the Division of Health Care Finance and Policy or other rate approving authority.

**Department -** the Department of Mental Health.

**Dependent -** shall mean:

1. the Patient or Fee Payer, if he or she maintains a home outside the Facility;
2. the Patient's or Fee Payer's spouse;
3. the Patient's or Fee Payer's Minor children;
4. any person over half of whose support for the previous twelve (12) month period was received from the Patient or Fee Payer.

**Facility -** a place providing psychiatric care and treatment designated as a facility under the control of the Department pursuant to 104 CMR 26.03, except for those Department-operated psychiatric units in public health hospitals.

**Fee Payer -** any of the following persons, each of whom may be liable for Charges for care or services pursuant to M.G.L. c. 19 and c. 123:

- the Patient;
- the spouse of a Patient, unless such spouse is legally separated, then only to the extent provided by judicial order or separation agreement;
- a guardian, conservator, representative payee, or other person who controls assets of the Patient or the Patient's spouse; however, the guardian, conservator, representative payee, other representative or other person is not a Fee Payer with respect to his or her personal assets.

**Income** - monies received as recurrent payments, payments in kind or lump sum payments. Income shall be defined as such monies in the month received, and thereafter such monies shall be defined as assets.

**Medicaid** - The program of medical assistance administered by the Massachusetts Division of Medical Assistance in accordance with Title XIX of the Social Security Act and M.G.L. c. 118E.

**Minor -** any person under the age of eighteen (18) years.

**Patient -** a person who is or was receiving care and treatment in a Facility.

**Personal Needs Allowance** - an amount of monthly Income determined by the government to be used solely for a Patient's personal needs.

## VI. PROCEDURES

### A. Notice for Charges for Care

Patients shall receive notification, in accordance with 104 CMR 30.04 (5), of Charges for care for services for which a Charge has been established. Attachment #1 (Form #1) shall be used for this purpose.

### B. Assessment of Charges for Care

1. Charges for Care
    a. the Department will charge for care and treatment of any Patient
    b. the Charge shall be the Approved Rate

2. Clients with Insurance

Pursuant to 104 CMR 30.04 (7), the Facility shall use a Patient's insurance or other available third party reimbursement, whenever available, as payment for the care or services that it provides. Upon admission, and periodically thereafter, the Facility director, or his or her designee, shall inquire of each Patient, and his or her fiduciary, if any, whether the Patient has or is eligible for insurance or other third party reimbursement for the care and services being provided by the Facility and its staff. Attachments #2 and #3 (Forms # 2 and #3) shall be used for this purpose. If a Patient is eligible for but does not have third party reimbursement that would reimburse the Facility for the Patient's care and services, the Facility shall use reasonable efforts either to assist the Patient with applying for such benefits or to apply for such benefits on behalf of the Patient.

a. Assessments for the cost of care of any Patient enrolled in or subject to a contract of insurance or other third party reimbursement contract or entitlement shall be the total amount payable under such insurance, contract, or entitlement up to the Approved Rate. In such instances, the Department shall recover said Charge by making a claim against such insurance, contract or entitlement.

b. If such insurance, contract or entitlement provides for payment of less than the Approved Rate, the Department shall assess the Patient or other Fee Payer for the remaining balance by application of the standards set forth in Section VI. C. through F. of this policy, provided however, that the amounts payable towards any such remaining balance for a Patient who is enrolled in the Medicaid program

shall be the amounts as determined in accordance with Section VI. E. of this policy.

3. Clients Without Insurance

Assessments for the cost of care of any Patient not covered by a contract of insurance or other third party reimbursement contract or entitlement shall be at the Approved Rate, provided however, that adjustments to said Charge shall be made by the Department for each such Patient or Fee Payer in the manner specified in Section VI. C. through F. of this policy. The Charge, after adjustments, shall be billed against the Income and assets of the Patient or Fee Payer in the manner specified in Section VI. G. of this policy.

**C. Adjustment to Charges for Care**

1. If a Patient does not have insurance, a "Financial Information for the Determination of the Reduction of Charges for Care" form, Attachment #4 (Form #4) shall be completed. The Area/Facility Billing Office will adjust Charges and bill using the financial information on this form.

2. The adjusted Charge shall be calculated using the information supplied on the Financial Information for the Determination for the Reduction of Charge form and applying that information to the "Reduction of Charge Calculation Worksheet." (See Attachment #5, Form #5). Using the following criteria:

a. The adjusted Charge amount shall be calculated in monthly amounts. Patients having a period of care less than a month, shall receive a prorated adjusted Charge.

b. For care provided to a Patient for each full calendar month, the Department shall calculate a monthly adjusted Charge, specific to the individual's circumstances.

c. The monthly adjusted Charge shall be determined by calculating the Patient's or Fee Payer's adjusted annual Income, and by determining the number of Dependents the Patient or Fee Payer may claim. After determining these figures, the monthly adjusted Charge is found by referencing the table in Section D of this policy.

d. The adjusted annual Income is calculated in the following manner: gross anticipated Income, plus assets, less permitted deductions.

(1) <u>Computation of Gross Income</u>
Gross Income is Income expected to be received by the Patient, by the Fee Payer on behalf of the Patient, or the Patient's spouse, over the next twelve

(12) months. This figure is determined by adding all anticipated Income from whatever source derived, including the following sources:

(a) compensation for services (If compensation to the Patient is terminated by reason of admission to the Facility and if there is no guarantee that the Patient will receive compensation during the next twelve month period, the Patient's compensation shall be considered zero.);
(b) net Income derived from a business;
(c) interest;
(d) net rental Income;
(e) dividends;
(f) annuities;
(g) pensions;
(h) unemployment compensation, workmen's compensation;
(i) royalties;
(j) Veteran's Administration compensation;
(k) Social Security Retirement, Supplemental Security Income or Supplemental Security Disability Income Benefits;
(l) Trust distributions.

(2) Computation of Liquid Assets
Liquid assets are cash and all assets capable of ready conversion into cash including (but not limited to) the following items:

(a) bank deposits;
(b) stocks, bonds, and securities. Liquid assets do not include life insurance or its cash value. Liquid assets include any assets not withstanding whether the individual holds interest to such assets either jointly or solely, and do not include assets subject to an irrevocable trust with the Patient as a named beneficiary, unless those assets are available to the Patient on demand.

(3) Computation of Deductions

Deductions shall include the following:
(a) For Patients with liquid assets which are deemed countable assets by the Medicaid Program for purposes of establishing or maintaining eligibility, one thousand dollars ($1,000) shall be deducted for each such Patient.
(b) The Personal Needs Allowance, as defined by federal law, annualized to a yearly figure, shall be deductible for each Patient who receives such allowance.
(c) Reasonable expenses incidental to the Patient's present and future rehabilitative needs shall be deducted when determining the Patient's or

other Fee Payer's adjusted annual Income. Such expenses or deductions include, but are not limited to, the following:

- reasonable transitional expense, including, when appropriate, deposits to saving accounts, necessary to enable the Patient to move from the Facility to a less restrictive living environment;
- Income received as a result of employment in a sheltered workshop, or other habitation program;
- the cost of premiums required to enroll and maintain the Patient in a health insurance program;
- medical and dental expenses of the Patient;
- transportation expenses, including costs of commuting to work.

(d) Miscellaneous expenses. In addition to the foregoing specific deductions, certain miscellaneous reasonable expenses, as determined by the Facility, may be permitted as deductions, on a case-by-case basis. Adjusted Charge figures in the Adjusted Monthly Charge Table (Section 4 below) take into account average expenses at each level of income for food, housing, transportation, clothing, personal care, taxes, recreation, and other adjustments. Other allowable expenses, not reflected in the adjusted Charge figures, may be deducted from the sum of gross Income plus liquid assets to the extent that these other allowable expenses do not exceed reasonable amounts. These expenses include but are not limited to:

- alimony payments;
- loan payments, except purchase money mortgages on real estate (which is already included in the adjusted Charge table), but only if the loan was incurred to pay for an allowable expense;
- funeral expenses;
- college tuition;
- uniforms or tools if required by the job and required to be purchased by the employee; and
- child support and day care expenses.

**D. Adjusted Monthly Charge**

The adjusted monthly Charge is determined using the following table:

| Adjusted Annual Income | | Dependents | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| | | | The maximum monthly fee is -- | | | | | | |
| $ 0,000. | $ 1,999. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2,000. | 2,999. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 3,000. | 3,999. | 128 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4,000. | 4,999. | 211 | 30 | 0 | 0 | 0 | 0 | 0 | 0 |
| 5,000. | 5,999. | 295 | 55 | 0 | 0 | 0 | 0 | 0 | 0 |
| 6,000. | 6,999. | 378 | 138 | 30 | 0 | 0 | 0 | 0 | 0 |
| 7,000. | 7,999. | 461 | 222 | 85 | 0 | 0 | 0 | 0 | 0 |
| 8,000. | 8,999. | 545 | 305 | 168 | 31 | 0 | 0 | 0 | 0 |
| 9,000. | 9,999. | 628 | 388 | 251 | 114 | 30 | 0 | 0 | 0 |
| 10,000. | 10,999. | 711 | 472 | 335 | 198 | 61 | 0 | 0 | 0 |
| 11,000. | 11,999. | 795 | 555 | 418 | 281 | 144 | 30 | 0 | 0 |
| 12,000. | 12,999. | 868 | 616 | 472 | 328 | 185 | 41 | 0 | 0 |
| 13,000. | 13,999. | 941 | 677 | 526 | 376 | 225 | 74 | 0 | 0 |
| 14,000. | 14,999. | 1014 | 738 | 581 | 423 | 266 | 108 | 0 | 0 |
| 15,000. | 15,999. | 1087 | 799 | 635 | 471 | 306 | 142 | 0 | 0 |
| 16,000. | 16,999. | 1160 | 860 | 689 | 518 | 347 | 175 | 0 | 0 |
| 17,000. | 17,999. | 1233 | 921 | 743 | 565 | 387 | 209 | 31 | 0 |
| 18,000. | 18,999. | 1306 | 982 | 798 | 613 | 428 | 243 | 58 | 30 |
| 19,000. | 19,999. | 1379 | 1043 | 852 | 660 | 468 | 277 | 85 | 49 |
| 20,000. | 20,999. | 1462 | 1127 | 935 | 743 | 552 | 360 | 168 | 132 |
| 21,000. | 21,999. | 1546 | 1210 | 1018 | 827 | 635 | 443 | 251 | 215 |

In the event the number of Dependents exceeds seven (7), the adjusted monthly Charge shall be the Charge set for seven (7) Dependents minus $36 for each Dependent in excess of seven (7). In the event the adjusted annual Income equals or exceeds $22,000, the adjusted monthly Charge is the adjusted monthly Charge for an individual with $22,000 of adjusted Income plus $83 for each additional $1,000 of adjusted annual Income in excess of $22,000.

**E. Application of Income to Medicaid-Eligible Patients to Charges for Care**.

If after submission of a claim to the Medicaid program, the Department does not receive full reimbursement for the cost of care at the Approved Rate, the Department shall Charge Medicaid-eligible Patients for the difference between the amount received from Medicaid and the Approved Rate, subject to the following restrictions:

1. Patients shall be entitled to retain Income in the following amounts:
   - an amount equal to the Personal Needs Allowance as set by law;
   - an amount for the maintenance needs of the Patient's spouse at home;
   - an amount for the maintenance needs of the Patient's family at home;
   - an amount for health insurance premiums, deductibles, and co-insurance Charges;
   - an amount for necessary medical or remedial care not subject to coverage under the Medicaid program and;
   - an amount for maintenance of the Patient's home.

2. In addition to Section VI. E. 1. above, the Department shall permit Patients to retain additional Income based upon the following criteria:

   - reasonable transitional expenses, including, when appropriate, deposits to savings accounts, necessary for the Patient to move from the Facility to a less restrictive living environment;
   - such amounts as are directly related to the Patient's rehabilitation, education, training and medical care over and above that provided by the Facility, including, but not limited to, the following: food, clothing, transportation expenses, recreation, and expenses incident to leisure time activity.

3. The amount or the adjusted Charge shall be the difference between the Medicaid-eligible Patient's Income and the above deductions.

**F. Maximum Yearly Charge**.

1. For Patients and Fee Payers subject to the provisions in Section VI. B. 2. b. and 3., the accumulated total monthly Charges shall not exceed in any twelve (12) month period the maximum yearly Charge.

2. The maximum yearly Charge shall be calculated by first determining the number of Dependents and the total of gross Income plus liquid assets of the Patient or Fee Payer minus one thousand dollars ($1,000) and then multiplying the sum of those monies times:

| | | | |
|---|---|---|---|
| 20.0% | where total Dependents equal | | 0 |
| 17.5% | " | " | 1 |
| 15.0% | " | " | 2 |
| 12.5% | " | " | 3 |
| 10.0% | " | " | 4 |
| 7.5% | " | " | 5 |
| 5.0% | " | " | 6 |
| 2.5% | " | " | 7 |
| | | or more | |

The resultant product shall equal the maximum yearly Charge.

**G. Collection of Charges**.

1. The Department shall collect Charges for care from the Patient or other Fee Payer, provided however, that collection of said Charges be subject to the following restrictions:

2. Personal Needs Allowance. Any Patient who is a recipient of benefits issued under the Social Security Retirement, Supplemental Security Income or Supplemental Security Disability Income programs of the Social Security Administration, shall be entitled to retain that portion of the benefit which is designated a Personal Needs Allowance under law.

3. Funds held in a fiduciary arrangement. The Department shall not collect Charges for a Patient's care from or against any assets held or maintained for the benefit of the Patient in:

a. an irrevocable trust; or

b. any fiduciary arrangement which renders the assets not countable as assets of the Patient for purposes of determining eligibility for the Medicaid program.

4. Other Funds. Each Patient shall be entitled to retain one thousand dollars ($1,000) cash or personal property.

5. Income and Assets of Fee Payers other than the Patient.

a. Income and assets of Fee Payers other than the Patient shall not be subject to collection by the Department, provided however that the Department may collect Charges from such Income and assets in the following instances:

(1) Spouse of Patient. Income and assets of spouses of Patients are subject to collection by the Department, unless such spouse is legally separated from such Patient. In the event of such legal separation, such spouse shall be liable only to the extent provided by judicial order or separation agreement.

(2) Fiduciaries. Guardians, conservators, and other fiduciaries shall be liable only to the extent that they hold Income or assets of the Patient or persons listed in Section VI. G. 5. a. (1).

b. In the event that the Income and assets of the Fee Payer are subject to collection pursuant to this policy, the Charge for care shall be billed according to the standards set forth in 104 CMR 30.04 (6) and (7) and this policy. Where those standards require an adjustment to the Charge for care, then the Income and assets of the Fee Payer shall be used to compute the adjustment.

**H. Facility Director's Authority**

The withdrawal of Patient funds for the payment of adjusted Charges must comply with 104 CMR 30.04 (9) and the Department's Patient Funds Policy # 97-6 or its successor.

**I. Notice of Adjusted Charges**

A **"**Notice of Adjusted Charges" form (Attachment #6, Form #6) shall be mailed or delivered to the Patient, Fee Payer or other representative once it has been prepared.

**J. Review of Ability to Pay**

The Department shall provide for and shall review the Patient or other Fee Payer's ability to pay:

1. annually;
2. on request of the Patient or other Fee Payer or his representative; and
3. whenever the Department has reason to believe that the Patient's or other Fee Payer's ability to pay has changed.

**K. Change in Circumstances**

All Patients or other Fee Payers are required to report circumstances which would result in a change in the adjusted Charge, computed pursuant to 104 CMR 30.04 and this policy, a change in the party to be billed, or a change in the funds subject to collection pursuant to this policy.

**L. Stay of Charges**

If a Patient has, in the opinion of the Department, taken affirmative steps to become eligible for the Medicaid program or other insurance benefits, including steps to create an irrevocable trust or other fiduciary arrangement, then Charges shall be stayed pending Medicaid or other insurance eligibility determination, provided all other conditions of 104 CMR 30.04 and this policy are met. Charges shall be stayed by the Department only for such period of time as, in the opinion of the Department, the Patient is continuing to act in good faith to render him or herself Medicaid-eligible.

**M. Appeals of Adjusted Charges for Care**

The Patient, or other Fee Payer, shall have the right to appeal the amount of the adjusted Charges for care. The Department of Mental Health Charges for care regulation, at 104 CMR 30.04 (10) provides that the Commissioner or designee will hear the appeal of adjusted Charges for care. Each Facility director will hear such appeals by or on behalf of the Patients in his or her Facility. An appeal hearing shall consist of the following:

- an explanation by the Facility of the legal basis for Charges and how funds collected are used;
- an explanation by the Facility of how the Charges were determined for the Patient, including presentation of financial data concerning the Patient's Income, assets, and allowable deductions, upon which the Charges were based;
- an opportunity for the Patient or his or her representative to demonstrate that incorrect financial data was used;
- an opportunity for the Patient or his or her representative to present orally or in writing reasons for his or her inability to pay the Charges, or to present other reasons that the Charges are inappropriate.

Within seven (7) days after the appeal is heard, the Facility director will determine if there is sufficient ability to pay the Charges, or determine new Charges based on the ability to pay, and notify the Patient or Fee Payer in writing of the decision and the reasons for the decision.

**N. Forms**

When reproducing the attached forms, each Facility should insert its name in the appropriate places on the form. In addition, the appropriate services with their Charges, with effective date(s) authorized, must be inserted on Attachment #1 (Form #1).

## VII. IMPLEMENTATION RESPONSIBILITY

Implementation of this policy shall be the joint responsibility of the Deputy Commissioner for Program Operations (or designee) and the Deputy Commissioner for Management and Budget (or designee).

The Central Office Revenue Division will be available to assist in interpretation of the Charge for care regulation and other appeal-related matters.

## VIII. REVIEW

This policy shall be reviewed within six months of its effective date and revised, as necessary.

# Attachment #1

## COMMONWEALTH OF MASSACHUSETTS
## DEPARTMENT OF MENTAL HEALTH

_____
Name of Facility

*NOTICE OF CHARGES FOR CARE*

In accordance with 104 CMR 30.04, the Department of Mental Health is authorized to make Charges for the care of any person in its facilities.

The Charge for service rates rendered by this Facility effective _____ which has been filed with the Division of Health Care Finance and Policy is:
date

| ROUTINE INPATIENT | BILLING UNIT | CHARGE |
|---|---|---|
| Acute-Admission | Pt. Day | $ |
| Acute-Intermediate | Pt. Day | $ |
| Continuing | Pt. Day | $ |
| Transitional | Pt. Day | $ |
| Forensic | Pt. Day | $ |
| Geri (Acute) | Pt. Day | $ |
| Geri (Extended) | Pt. Day | $ |

| ANCILLARY | BILLING UNIT | CHARGE |
|---|---|---|
| Laboratory | RVU's | $ |
| Radiology | RVU's | $ |
| Occupational Therapy | 15 minutes | $ |
| Physical Therapy | 15 minutes | $ |
| Psychology | 15 minutes | $ |
| Speech-Audiology | 15 minutes | $ |
| EKG | Test | $ |
| EKG | Test | $ |

You and your fiduciary, if any, have the following rights regarding payment for services rendered:

1. The right to have the Approved Rate adjusted based on you or your Fee Payer's (where applicable) personal circumstances. The Department representative listed at the end of this form will be in contact with you, and if applicable, your parents (if you are under 18), spouse, guardian, conservator or representative payee, to collect information necessary to determine what adjustments should be made, if any, to the approved Charges for care.

2. The right to review the financial information used to determine the adjusted Charge and to have an explanation of how the adjustment was determined.

3. The right to request a redetermination of the amount of the adjustment due to changes in your financial situation during your hospitalization.

4. The right to right to pay on a budget plan.

5. The right to appeal the calculation of Charges and the adjustments to the Facility Director within 30 days of being notified of the amount due. The right to be assisted by a person of your choice during the appeal process.

6. If you choose to appeal, your appeal will be heard by the Facility Director. The appeal hearing will consist of the following:

a. an explanation of the legal basis for Charges and how funds are collected and used;

b. An explanation of how the Charges were determined for the Patient, including presentation of financial data concerning the Patient's Income, assets, and allowable deductions, upon which the Charges were based.

c. an opportunity for the Patient and/or his/her legally authorized representative to provide documentation that incorrect financial data was used;

d. an opportunity for the Patient or his/her representative to present orally or in writing reasons for inability to pay the Charges, or to present other reasons that the Charges are inappropriate.

Within 7 days after the appeal is heard, the Facility Director should determine if there is sufficient ability to pay the Charges, or determine new Charges based on the ability to pay, and notify the Patient or Fee Payer in writing stating the reasons for the decisions.

Patient Care Reimbursement Investigator: _____

Telephone:_____

# Attachment #2

## COMMONWEALTH OF MASSACHUSETTS
## DEPARTMENT OF MENTAL HEALTH

*RELEASE OF INFORMATION FOR BENEFITS INQUIRY/THIRD PARTY REIMBURSEMENT*

Patient's Name_____

Date of Admission_____

Hospital No._____

1. I authorize _____ to obtain any and all information relative to my
(name of Facility)
eligibility for financial and/or medical benefits either public or private which would be available to pay for the cost of my care and treatment at this Facility during this current admission.

2. If it is determined that I am eligible for any benefits or reimbursement, I authorize _____ to apply for these reimbursements and benefits on my
(name of Facility)
behalf and to apply monies received to the cost of my care and treatment.

3. I authorize _____ to contact the Social Security Administration,
(name of Facility)
Medicare Program, Medicaid Program, Department of Transitional Assistance and other public and private third party insurance carriers to determine the coverage and/or benefits for which I am eligible.

4. I also authorize _____ to release a copy of pertinent sections
(name of Facility)
of my medical record to my insurance carrier, if requested, to justify payment to the hospital for my care during this admission.

5. I authorize _____ to release my: name, date of birth, Social
(name of Facility)
Security number, current inpatient status, diagnosis and any other information that is needed to determine the coverage and benefits I am currently receiving and/or to apply for the appropriate coverage and/or benefits.

6. In addition, I authorize the agencies listed above to release to_____
(name of Facility)

and to the Department of Mental Health any information they have concerning my eligibility for benefits and reimbursements.

7. This authorization is valid for the current hospitalization and records pertaining to the current hospitalization and can be revoked at any time. If at a later date I revoke my authorization, I or my guardian must notify either the Facility Director or the Director of Medical Records in writing of this change.

**A copy of this release shall be considered as valid as the original.**

_____ _____

Signature of: (check one) Signature of Witness/Title
Patient _____
Guardian _____

_____
Date

If Patient or guardian refuse to sign, see following page regarding best interest determination.

Original Form To: Patient's Medical Record
Copy To: Patient Accounts Office

# Attachment #3

**COMMONWEALTH OF MASSACHUSETTS**
**DEPARTMENT OF MENTAL HEALTH**

**RELEASE OF INFORMATION FOR BENEFITS INQUIRY/THIRD PARTY REIMBURSEMENT**
**BEST INTEREST DETERMINATION**

_____

Patient Name

STEP I

Patient or Guardian refused to sign:_____
Date

Reason: (must be completed) _____
_____
_____
_____

_____
SIGNATURE: Witness/Title

STEP II

Sent to Facility Director _____ for best interest determination.
Date

After considering the relevant factors, I have determined that it (check one line only) ____is ____ is not, in this Patient's best interest:

[check one line only]
_____ for Patient information to be released for benefit inquiry
_____ to apply for third party reimbursement for this Patient
_____ to release Patient information to support an appeal of a denial of benefits

Reason for Facility Director's best interest approval or denial of approval (taking into consideration the foregoing reasons for refusal to sign): (must be completed)_____
_____
_____
_____
_____

| | |
|---|---|
| Signature of Facility Director | Date |

# Attachment #4

## COMMONWEALTH OF MASSACHUSETTS
## DEPARTMENT OF MENTAL HEALTH

*Financial Information for the Determination of Reduction of Charges for Care*

Facility: _____ Date: 1. ___/___/___

Admission Information:

Date of this admission: 2. ___/___/___ Patient Number: 3. ___/___/___/___/___/___/___/___
Mo. Day Yr.

If readmission, date of last discharge: 4. ___/___/___
Mo. Day Yr

5. ___/___/___/___/___/___/___/___/___/___/_____/___/___/___/___/___/___/___/___/___/__
. Last, First, Middle Initial

6. (___/___/___) ___:___:___:___:___:___:___ 7. ___/___/___/___/___/___/___/___/___/___
Telephone No. Street

8. ___/___/___/___/___/___/___/___/___/___/__ _ 9. ___/__ _ 10. ___/___/___/___/___/
City/ Town State Zip Code

Fee Payer's Name and Address:

11. ___/___/___/___/___/___/___/___/____/___/___/___/___/___/___/___/___/___/___/___/___
Last, First, Middle Initial
12: (___/___/___) ___:___: ___:___:___:___:___ 13. ___/___/___/___/___/___/___/___/___
Telephone No. Street
14. ___/___/___/___/___/___/___/___/___/___ 15. ___/__ _ 16. ___/___/___/___/___/
City/Town State Zip Code

Insurance Coverage:
17. ___/___/___/___/___/___/___/___/___/__ _ 18. ___/___/___/___/___/___/___
Insurer #1 Policy Number

19. ___/___/___/___/___/___/___/___/___/__ _ 20. ___/___/___/___/___/___/___
Insurer #2 Policy Number

Dependents:
Does either the Patient or the Patient's spouse maintain a household separate from this Facility?
21. Yes___ No ___

How many other Dependents does the Patient have (include spouse, children under eighteen years of age, and other individuals deriving 50% or more of their support from Income of Patient or of Patient's spouse)?
22. ____/____

DEPARTMENT OF MENTAL HEALTH
FINANCIAL INFORMATION

Patient Name:

23. ___/___/___/___/___/___/___/___/___/___/___/___/___/___/___/___/___
Last, First, Middle Initial

GROSS INCOME:
Salary/wages and net Income from business interest, net rental Income, dividends, trust distributions, annuities, pensions, royalties, or unemployment or workmen's or Veteran's Administration Compensation, or Social Security. Retirement, Supplemental Security Income or Supplemental Security Disability Income Benefits

| SOURCE | AMOUNT |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Total Gross Income: 24. $ __/__/__/__/__/___

LIQUID ASSETS:
Cash, bank deposits, stocks, bonds, trust assets available on demand, securities, etc., but not life insurance or its cash value.

| SOURCE | AMOUNT |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Total Liquid Assets 25. $ ___/___/___/___/___

ALLOWABLE DEDUCTIONS:
Such as medical and dental expenses, alimony, child support, day care, reasonable rehabilitative expense, loan payments (except mortgages), health insurance premiums, necessary employment expenses, including uniforms or tools required for job, funerals, college tuition, sheltered workshop Income, reasonable expenses for the education or transportation of a mentally disabled or handicapped person.

| SOURCE | AMOUNT |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Total Allowable Deductions: 26. $___/___/___/___

DEPARTMENT OF MENTAL HEALTH
FINANCIAL INFORMATION

I, _____ _ , certify that all information I have given
(Patient's or Patient's Representative's Name)

is accurate to the best of my ability, and I agree to notify this agency if there are any changes. I have been informed of and understand the rights regarding reduction in Charges for care as stated in the Admission Notice.

_____ _____

Address: _____ _____ _
Street City/State Zip Code

FOR OFFICE USE ONLY:

☐ Information supplied insufficient. (No reduction.) (Notice sent.)

☐ Information supplied sufficient. Calculation work sheet completed.) (Reduction notice sent.)

cc: Patient Billing Record

# Attachment #5

**COMMONWEALTH OF MASSACHUSETTS**
**DEPARTMENT OF MENTAL HEALTH**

*REDUCTION OF CHARGES CALCULATION WORKSHEET*

Facility: _____

Patient's Name: _____ Date:_____

Copy the appropriate information from the Financial Information Form, and perform the indicated calculations.

If Patient or spouse maintain a household enter "1" 27. _____

Enter the number of other Dependents 28. _____

Total Dependents: (Add items 27 and 28) 29. _____

Enter Total Gross Income 30. $_____.___

Enter Total Liquid Assets 31. $_____.___

32. $ (1,000.00)

Items 30 Plus Item 31 Less Item 32 Equals: 33. $_____.___

Enter the Appropriate % From the Table 34. _____%

Maximum Yearly Fee (Item 34 x 33)) $_____.___

Enter Total Allowable Expenses 35. _____.___

Item 33 Less Item 35: 36. _____.___
Maximum Monthly Fee From the Table $_____.___
(Use Items 36 and 29)

Completed by:

_____ _____
Signature and Title Date

# Attachment #6

**COMMONWEALTH OF MASSACHUSETTS**
**DEPARTMENT OF MENTAL HEALTH**

*NOTICE OF ADJUSTED CHARGES*

Patient Name:_____ Patient Billing #_____ Date: _____

_____
person responsible for the Patient's financial affairs (if different from Patient).

Facility: _____

Charges for care in Department of Mental Health facilities are at the rates established by the Division of Health Care Finance and Policy. The rate for this Facility is _____per day. Based on the Patient's financial situation, the Department has adjusted the Charges for this Patient's care as shown below.

For a Patient enrolled in Medicaid or other insurance program:

☐ A claim has been made to Medicaid or the Patient's insurance carrier to pay for the Patient's care. The claim is $_____ less than the full Charges.

☐ The adjusted Charges are $_____ effective _____.

For a sliding fee scale Patient:

☐ Charges are not to exceed $_____per day for partial months of care.
Charges are not to exceed $_____ per month, and
Charges are not to exceed $_____ for the 12 month period from
_____ to _____ .

The Department of Mental Health will bill these Charges to the person responsible for the Patient's financial affairs.

Questions about these Charges may be directed to:

_____
Name Address Telephone

IF YOU DISAGREE WITH THESE CHARGES

You have the right to dispute these Charges. If you disagree with these Charges, you may contact the above-named Department of Mental Health representative in writing or by telephone and receive an explanation of how the Charges were determined. You may review and obtain a copy of the financial data concerning the Patient's Income, assets, and allowable deductions, upon which the Department based its assessment of Charges for care. If you believe the Charges were incorrectly calculated or that incomplete financial data was used, you may request a reassessment of the Charges. The Charges will be re assessed and you will be notified of the results of the reassessment.

RIGHT TO APPEAL

As an alternative to having the Charges reassessed, or if you are dissatisfied with the reassessment, you may formally appeal the amount of the assessed or reassessed Charges. In order to appeal the Charges, you must within 30 days of the receipt of this notice, or the notice of the reassessed Charges, contact the above-named Department of Mental Health representative and state in writing that you wish to appeal the Charges. You will then be provided with a hearing to contest the Charges. At that hearing, you will be allowed to present oral or written statements, question the person(s) who assessed the Charges, and you may have an attorney or other advocate present to represent you. You will be given a notice of the time and place for such a hearing. If this notice has been mailed, it will be assumed that it took three (3) business days for you to receive it.