COASTAL HEALTH & WELLNESS

GOVERNING BOARD

9850-A.106 Boardroom Emmett F. Lowry Expressway, Texas City

AGENDA
Thursday, November 10, 2022 – 12:30 PM

CONSENT AGENDA: ALL ITEMS MARKED WITH A SINGLE ASTERICK (*) ARE PART OF THE CONSENT AGENDA AND REQUIRE NO DELIBERATION BY THE GOVERNING BOARD. ANY BOARD MEMBER MAY REMOVE AN ITEM FROM THIS AGENDA TO BE CONSIDERED SEPARATELY.

PROCEED TO BOTTOM OF THIS DOCUMENT FOR APPEARANCE & EXECUTIVE SESSION GUIDELINES

In accordance with the provisions of the Americans with Disabilities Act (ADA), persons in need of a special accommodation in order to participate in this proceeding should, within two (2) days prior to the proceeding, request necessary accommodations by contacting CHW's Executive Assistants at 409-949-3406, or via email at trollins@gchd.org or ahernandez@gchd.org

ANY MEMBERS NEEDING TO BE REACHED DURING THE MEETING MAY BE CONTACTED AT 409-938-2288

REGULARLY SCHEDULED MEETING

Meeting Called to Order
Pledge of Allegiance

Item #1 ..... Comments from the Public

***Item #2 ACTION** ..... Agenda

***Item #3 ACTION** ..... Excused Absence(s)

*Item #4 **ACTION** ..... Consider for Approval Minutes from October 27, 2022 Governing Board Meeting

Item #5 ..... Coastal Health & Wellness Updates
a) Current Public Health Concerns and Status; COVID/Flu/Monkey Pox Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c) Dental Updates Submitted by Dental Director

Item #6 **ACTION** ..... Consider for Approval Updated Bad Debt Policy and Write off Over 180 Days Submitted by Ami Cotharn

Item #7 **ACTION** ..... Consider for Approval Community Representative, Sergio Cruz to Serve as Lead on the Finance Committee

Item #8 ..... RCM Quality Project Update Submitted by Ami Cotharn

Item #9 ..... Comments from Board Members

Adjournment

Next Regular Scheduled Meeting: December 8, 2022

<u>Appearances before the Coastal Health & Wellness Governing Board</u>

The Coastal Health & Wellness Governing Board meetings are conducted under the provisions of the Texas Open Meetings

Act, and members of the public that wish to address the Board about an item presented on the agenda shall be offered three minutes to do so. The Board cordially requests that individuals desiring to make a such a statement notify the Board of their intention by writing their name on the sign-in sheet located at the Boardroom's main entrance.

A citizen desiring to make comment to the Board regarding an item not listed on the agenda shall submit a written request to the Executive Director by noon on the Thursday immediately preceding the Thursday of the Board meeting. A statement of the nature of the matter to be considered shall accompany the request. The Executive Director shall include the requested appearance on the agenda, and the person shall be heard if he or she appears.

Executive Sessions

When listed, an Executive Session may be held by the Governing Board in accordance with the Texas Open Meetings Act. An Executive Session is authorized under the Open Meetings Act pursuant to one or more the following exceptions: Tex. Gov't Code §§ 551.071 (consultation with attorney), 551.072 (deliberation regarding real property), 551.073 (deliberation regarding a prospective gift or donation), 551.074 (personnel matters), 551.0745 (personnel matters affecting Coastal Health & Wellness advisory body), 551.076 (deliberation regarding security devices or security audits), and/or 551.087 (deliberations regarding economic development negotiations). The Presiding Officer of the Governing Board shall announce the basis for the Executive Session prior to recessing into Executive Session. The Governing Board may only enter into Executive Session if such action is specifically noted on the posted agenda.

Governing Board
November 2022
Item#3
Excused Absence(s)

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Governing Board
November 2022
Item#4
Consider for Approval Minutes from October 27, 2022
Governing Board Meeting

Coastal Health & Wellness
Governing Board
October 27, 2022

Board Members:

Samantha Robinson
Rev. Walter Jones
Donnie VanAckeren
Ivelisse Caban
Elizabeth Williams
Victoria Dougharty
Clay Burton
Flecia Charles
Sergio Cruz

Staff:

Ami Cotharn, Chief Operations Officer
Dr. Choi, Medical Director
Hanna Lindskog, Dental Director
Trish Bailey, GCHD, CFO
Jason Borillo (zoom)
Neal Pathak
Mary Jones
Kenna Pruitt
Wendy Jones
Chris Davis
Virginia Lyle
Judie Olivares
Pisa Ring
Jennifer Koch
Ashley Tompkins
Tikeshia Thompson-Rollins
Anthony Hernandez

Excused Absence: Dr. Thompson, Kevin Avery, Cynthia Darby, and Sharon Hall
Unexcused Absence: Miroslava Bustamante,
Guest: Dr. Courtni Tello

Items#1 Comments from the Public
There were no comments from the public.

Items#2-10 Consent Agenda
A motion was made by Sergio Cruz to approve the consent agenda items two through ten. Ivelisse Caban seconded the motion, and the Board unanimously approved the consent agenda.

Item#11 Coastal Health & Wellness Updates

a) Update on COVID-19 Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c) Dental Updates Submitted by Dental Director

Ami Cotharn, Chief Operating Officer, presented the October 2022 Coastal Wave.

Ami Cotharn, Chief Operating Officer, updated the Board on clinical operations.

New Hire

- Two positions filled this month.
  - Medical/Dental Insurance Verification Specialist
  - Dental Assistant position filled

Outreach

- Four outreach events scheduled for the month.
  - GCHD Health Fair – Texas City Moore Memorial Library
  - Veteran Food Distribution– All programs
  - Diabetes Ed Class – Santa Fe Library – CIHCP information
  - Day of the Dead – Texas City – All programs

Hanna Lindskog, updated the Board on dental services in the Coastal Health & Wellness Clinic:

- The dental clinic continues to follow CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel which has a section dedicated to Dental Facilities. We are wearing N95 respirators for all aerosol generating procedures.
- The College of the Mainland is continuing to develop their Dental Hygiene Program. We have our next meeting on November 15th, 2022.
- In the month of September, we completed 73 comprehensive exams on new patients (decrease of 2). We continue to offer new patients acute appointments to address immediate needs so that no one in pain is waiting. We had a total of 205 Acute visits in the month of September, which is a slight decrease compared to August. 69 of those patients were either new to our clinic or had not been here in over 3 years. In the month of August, 114 extractions (decrease of 8 compared to August) and 211 restorative procedures (decrease of 37 compared to August) were completed. We had one full time provider and one part time provider out for one week in September.
- We had our second meeting for the NNOHA Teledentistry Collaborative on October 5th. This is a virtual collaborative and several dental clinic staff members are participating including one of our full-time dentists (Dr. Shetty), the Dental Director, and Dental Assistant Supervisor. Our second meeting included presentations of how other health centers have incorporated teledentistry. The next collaborative meeting is scheduled for November 2nd.
- Staffing: We had a new dental assistant start last week and are now full staffed
- Dr. Lindskog attended the City of Texas City Senior Program at Nessler Park on October 21st. A presentation was given, and folders were given out with helpful oral hygiene tips.
- The Dental Clinic will have a table at the TurkeyTrot event on November 12, 2022.
- Wait list: 737 (decrease of 85 people)

Item#12 Consider for Approval Preliminary September 2022 Financial Report Submitted by Trish Bailey

Trish Bailey, Chief Finance Officer, presented September 2022 Financial Report. A motion to accept the financial report as presented was made by Sergio Cruz. Rev. Walter Jones seconded the motion and the Board unanimously approved.

Item#13 Consider for Approval Quarterly Visits and Analysis Report Including Breakdown of New Patients by Payor Source for Recent New Patients Submitted by Ami Cotharn

Ami Cotharn, Chief Operating Officer, asked the Board to consider for approval quarterly visits and analysis report including breakdown of new patients by payor source for recent new patients. Samantha suggested doing a drill down on the number of pediatric patients seen by financial class. A motion to accept the report as presented was made by Rev. Walter Jones. Victoria Dougharty seconded the motion and the Board unanimously approved.

Item#14 Consider for Approval the Quarterly Compliance Report for the Period Ending September 30, 2022 Submitted by Wendy Jones

Wendy Jones, Compliance & Risk Management Officer, presented to the Board the quarterly compliance report. A motion to accept the report as presented was made by Victoria Dougharty. Rev. Walter Jones seconded the motion and the Board unanimously approved.

Item#15 Consider for Approval Coastal Health & Wellness Quality Assurance Performance Improvement Plan 2022-2023 "QAPI" Submitted by Jason Borillo

Jason Borillo, Director of Innovation and Clinical Quality, asked the Board to consider for approval Coastal Health & Wellness Quality Assurance Performance Improvement Plan 2022-2023. Samantha Robinson

suggested adding HIV and Immunizations to the next annual review. A motion to accept the plan as presented was made by Flecia Charles. Elizabeth Williams seconded the motion and the Board unanimously approved.

Item#16 Consider for Approval Coastal Health & Wellness Title V Child Health & Dental Eligibility Policy Submitted by Jennifer Koch

Jennifer Koch, Outreach, Eligibility and Enrollment Manager, asked the Board to consider for approval Coastal Health & Wellness Title V Child Health & Dental Eligibility Policy. Jennifer informed the Board there were no changes to the policy. A motion to accept the policy as presented was made by Victoria Dougharty. Sergio Cruz seconded the motion and the Board unanimously approved.

Item#17 Consider for Approval Consumer Board Member Cynthia Darby to serve on the Appointing Committee Submitted by Samantha Robinson

Samantha Robinson, Board Chair, asked the Board to consider for approval consumer Board member Cynthia Darby to serve on the appointing committee. A motion to accept Cynthia Darby on the appointing committee was made by Rev. Jones. Ivelisse Caban seconded the motion and the Board unanimously approved.

Item#18 Consider for Approval Consider for Approval Nominee Courtni Tello, RDH, DDS to fill the Community Representative/Interim Vice Chair Position through June 2023

Samantha Robinson, Board Chair, asked the Board to consider for approval nominee Courtni Tello, RDH, DDS to fill the community representative/intern vice chair position through June 2023. A motion to accept nominee Dr. Tello as presented was made by Flecia Charles. Donnie VanAckeren seconded the motion and the Board unanimously approved.

Item#19 RCM Quality Project Update Submitted by Ami Cotharn

Ami Cotharn, Chief Operating Officer, updated the Board on the RCM Quality Project. Ami informed the Board we go live with in house billing November 1st.

Item #20 Comments from Board Members

Ivelisse Caban, wanted to recognize Angela Villareal and Sonya Manning for their outstanding customer service and going above and beyond for our CHW patients. Ivelisse Caban suggested having suggestion card in the clinic for patients to fill out for staff.

The meeting was adjourned at 1:52p.m.

_____ _____

Chair Secretary/Treasurer

_____ _____

Date Date

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Governing Board
November 2022
Item#5
Coastal Health & Wellness Updates

a) Current Public Health Concerns and Status; COVID/Flu/Monkey Pox Submitted by Executive Director
b) Operational Updates/Coastal Wave Submitted by Chief Operating Officer
c) Dental Updates Submitted by Dental Director

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Governing Board
November 2022
Item#6
Consider for Approval Updated Bad Debt Policy and Write off Over 180 Days Submitted by Ami Cotharn

Revenue Cycle Management Policies and Procedures

Updated November 2022

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I. COASTAL HEALTH & WELLNESS MISSION, VISION, & VALUES

Our Mission

Providing high quality healthcare to all

Our Vision

Healthy people in healthy communities

Our Values

I CARE

Integrity- We are honest, trustworthy and transparent in all we do.

Customer Service- We are committed to providing exceptional customer service.

Accountability- We hold ourselves to high standards and take responsibility for our actions.

Respect- We uphold a standard of conduct that recognizes and values the contributions of all.

Equality- We equally value and serve all members of the community.

Coastal Health & Wellness does not discriminate any person based on race, color, national origin, sex, age, religion, or disability in our programs, services, or employment.

II. INSURANCE VERIFICATION POLICY & PROCEDURES

Related Form: Patient Responsibility

Related Policy: Billing and Collections, Payment Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

1. It is the policy of Coastal Health & Wellness (CHW) to verify patient benefits, including any payers that may have payment responsibilities. While verifying and documenting patient and insurance responsibilities, specific processes are to be followed so that the information is accurate, stored correctly, easily accessible and documented in an understandable manner. These processes also promote the sending of claims to the proper payer source to avoid delays in payments.
2. CHW makes every reasonable effort to enter into contractual or other arrangements to collect reimbursement of its costs with the appropriate agency(s) of the State which administers or supervises the administration of:
    a. A State Medicaid plan approved under title XIX of the Social Security Act (SSA) [42 U.S.C.1396, et seq.] for the payment of all or a part of the center's costs in providing health services to persons who are eligible for such assistance; and
    b. The Children's Health Insurance Program (CHIP) under title XXI of the SSA [42 U.S.C. 1397aa, et seq.] with respect to individuals who are State CHIP beneficiaries
3. CHW acknowledges the importance of identifying and documenting appropriate payer sources. The insurance verification process is performed by the billing /registration departments to promote: (i) listing the proper insurance on a patient's account; (ii) coordinating benefits so that claims are timely and accurately filed; (iii) identifying any patient responsibility and (iv) determining the payer of last resort for patients with multiple coverages/payers.
4. Patient benefits/appropriate payers are verified forty-eight (48) hours prior to the patient's appointment.
5. Medicaid eligibility can change from one month to the next. As a result, Medicaid eligibility is verified on the first business day of the month of the appointment.
6. Patients with a Medicaid application pending approval from the state are assigned an insurance carrier/status of "Medicaid pending" until Medicaid coverage is confirmed.

Procedure

The verification process for each department can vary. As such, specific instructions for verification are separated by area of specialty. Team members are assigned individual schedules to verify. Generally, schedules should be verified at least two days in advance. This allows the verification specialist, front desk,

and call-center staff the time to clarify any issues of coverage with the insurance plan and the member prior to the appointment.

1. The patient registration is where information is recorded by verification team members. While determining and documenting patient and insurance responsibility, there are specific processes that must be followed to ensure that the information is stored correctly and in a manner that can be seen and understood by all. These processes also help to ensure that the claims are sent to the proper payer source.
2. Determine the primary payer source for medical visits. This information should be entered into the Insurance tab in the patient's registration. All other insurance carriers should be unchecked, even if they are active.
3. Click Insurance Eligibility to open the Additional Policy Information tab. Enter in effective dates, coinsurance and deductible amounts, and any other relevant eligibility data. Click Active Coverage for active policies or Pending Verification for policies that require additional information to verify. Any policy that is known to be inactive should not be primary.
4. Ensure that the Financial Class correspond to the primary payer.
5. Verify that the patient's name, date of birth, and ID number match the insurance plan if applicable.
6. Verify if any secondary or ancillary policies are active and enter Insurance Eligibility information in the Additional Policy information tab. Do not leave the policy checked, even if it is active.
7. Open the Appointments tab and find the appointment for which you are verifying insurance.
8. Right click on the appointment and choose Modify Appointment.
9. Build or apply any relevant case information.
10. Double click the space next to the line labeled Appointment. Enter in any information that needs to be conveyed or has been conveyed to the patient for that particular appointment. The note should include the dollar amount the patient is responsible for and the payer source for the visit should be identified. End the note with the date and your initials. Click OK to save and close.
11. Save and exit the patient registration.

Medicaid Pending

- Use to check if patient has applied
- This report requires minimal input data.
- Choose insurance
- Click "View Report"

Creating and Applying Cases

Cases are created when a visit requires a different insurance carrier for a service rather than their primary medical insurance. For example, Traditional Medicaid does not cover sports physicals and patients must Self-Pay for this. Therefore, you would want to apply a Self-Pay case to **THAT APPOINMENT only**. This

ensures that their primary medical insurance continues to be billed for all covered services and that no claims go out to the wrong carrier for non-covered services.

Ryan White Verification

Part of the verification process for Ryan White patients is to eliminate the possibility of other payer sources before assigning responsibility to the grant. Verification must check that each patient does not have access to Medicaid or Medicare and the front desk must ask the patient if they have insurance prior to every visit.

Patients are qualified for the grant at registration sites and are assigned character codes that can be entered into the Centralized Patient Care Data Management System (CPCDMS/Aries) to verify. They are then assigned copays based on their poverty level. If FPL is over 100%, they are assigned a cap. Medicare and Medicaid verification is done by either running the Emdeon Report daily or manually on each website (typically done when it's a same day appt). Please see instructions on how to access and run the "Emdeon Report" under the Insurance Verification section

Self-Pay & Sliding Scale

For office visits (including well exam, HRT, and STD testing) follow the Sliding Fee Scale.

Primary Care Verification

- Traditional – no PCP assignment
- Star/Star Plus – PCP should be CHW
- No copay
- Primary care, FP services, annual wellness, some immunizations
- If active TPA is listed, Medicaid is secondary
- As secondary, covers copays and co-ins for services covered under plan

Medicare NGS / Medicare Novitas

- No PCP assignment
- Copay – slide if applicable
- Primary care, FP services, annual wellness, some immunizations
- As secondary, covers copay and co-ins for services covered under plan

Medicare Advantage Plans

- Replace original Medicare
- May be PPO or HMO
- May require PCP assignment
- Must determine in or out of network
- Copays and co-ins vary
- Primary care, FP services, annual wellness, some immunizations
- As secondary, covers copays and co-ins for services covered under plan

Private Insurance

- Must determine in or out of network

- Ensure service is covered
- Copays and co-ins vary
- Deductible may apply
- Has secondary plan?
- Health funds or accounts?

CHC – Harris Health

- No copays
- Must be referred by Harris Health

PHC Grant –Beaumont Clinics Only

- Active for one year from certification
- Primary care, FP services, annual wellness, immunizations

Ryan White Grant – LMC & BCC Clinics Only

- Payer of last resort – Must check for Medicare & Medicaid
- Eligibility verified through CPCDMS
- If FPL over 100%, must verify copay & cap amount

Health Texas Women Program

- Covers females only for 3 providers visit for the plan year
- Annual family planning and preventative healthcare visit
- Contraceptive services, all methods except elective abortion & emergency contraception (includes follow-up and surveillance)
- Preconception care
- Basic infertility services
- Certain screening, diagnostic, and treatment services:
- Pregnancy testing
- Screening and treatment of Cervical Intraepithelial Neoplasia, dx of cervical cancer
- Screening and outpatient treatment of STD's and STI's
- HIV testing
- Breast cancer screening and dx
- Recommended immunizations
- Screening and treatment of postpartum depression
- Diabetes screening and treatment
- Hypertension screening and treatment
- Screening and treatment of elevated cholesterol

Pediatric

Traditional Medicaid

- No PCP assignment

- No copay
- Acute care, FP services, well child, immunizations
- If an active TPA is listed, Medicaid is secondary
- As secondary, covers copays and co-ins for services covered under plan

Star & Star Plus Medicaid / CHIP

- PCP should be CHW
- MCD no copay / CHIP copay varies
- MCD - Acute care, FP services, well child, immunizations
- CHIP – Acute care, well child, NO FP, immunizations
- If an active TPA is listed, plan is secondary
- As secondary, covers copays and co-ins for services covered under plan

Private Insurance

- Must determine in or out of network
- Ensure service is covered
- Copays and co-ins vary
- Deductible may apply
- Has secondary plan

Medicaid Pending

- Check TMHP for coverage
- Coverage Found
- Add coverage to registration
- Update collections staff

No Coverage Found

- Newborn Under 3 months – keep Medicaid pending status
- Newborn over 3 months – send to eligibility
- Infants & older with Medicaid pending status less than 2 months – keep Medicaid pending status
- Infants & older with Medicaid pending status over 2 months – send to eligibility

Sports Physicals

- Uninsured follow slide
- Private Insurance Copay applies
- Traditional MCD – no coverage, self-pay
- CHIP Plans
- TCHP, AMG, Molina – Charge copay
- CHC, UHC – No copay

Immunizations

- Medicaid/Medicaid HMOs – No charge
- Private insurance verifies independently – if no coverage, self-pay rate applies.

OB/GYN Verification

- Copays and co-ins vary
- We are a Non-delivering provider. Phone call is required to determine coverage.
- Deductible may apply
- Has secondary plan?
- Health funds or accounts?

Healthy Texas Women

- Covers females only
- Annual family planning and preventative healthcare visit
- Contraceptive services, all methods except elective abortion & emergency contraception (includes follow-up and surveillance)
- Preconception care
- Basic infertility services
- Certain screening, diagnostic, and treatment services:
- Pregnancy testing
- Screening and treatment of Cervical Intraepithelial Neoplasia, dx of cervical cancer
- Screening and outpatient treatment of STD's and STI's
- HIV testing
- Breast cancer screening and dx
- Recommended immunizations
- Screening and treatment of postpartum depression
- Diabetes screening and treatment
- Hypertension screening and treatment

Specialty Services - Endocrinology/Geriatrics

When verifying for Specialty Services visits a phone call is required to all commercial plans (Aetna, BCBS, Cigna, Humana, etc.) to determine if visit is a specialist copay and/or if referral is required. Create/apply case if applicable.

Vision

Routine Vision

An optometrist and diagnoses refractive vision errors. He writes prescriptions for eyeglasses and contact lenses. He can see patients for medical issues, but this is usually only if an ophthalmologist is not available.

A Certified Ophthalmological Assistant assists patients with glasses and contact lenses. The two appointment types you will see on her schedule are Dispense and Frame Style.

Associated terms: REE/CEE – Routine/Complete Eye Exam, CLS – Contact Lens, RX check

- RX Check – Should be done within short period after REE/glasses dispensed. There is no charge.
- CLS F/U – Appointment is to order supplies of contact lens after the trial period is over.

Medical Vision

An ophthalmologist is a Specialty MD. He/she screens, diagnoses, and treats diseases of the eyes. A Certified Ophthalmological Assistant assists the Ophthalmologist and also assists patients with glasses and contacts. The two appointment types for her are Visual Field and Dispense.

Associated terms: CMV – Cytomegalovirus (screening), Diabetic Retinopathy, Visual Field

- Visual Field – A patient will be put on both Eva and Dr. Sawyer's schedule for a visual field exam. For Self-Pay/Sliding Scale patients, the cost is included in the price of Dr. Sawyer's visit.
- Dispense Visits – For RW visits, check eligibility as usual, but no copayment is collected. Self-Pay, Sliding Scale, and Medicaid Dispense visits are included in the cost of the glasses.

***HIV positive patients will usually be scheduled to see both doctors on the same day. This means you will have to ask for two/three separate benefits when calling to verify for these patients.**

Traditional Medicaid and Medicaid MQMB

Cover both REE and medical vision visits with no copayment.

- Adults 19 and up – one exam and 1 pair of glasses every TWO YEARS
- Children through 18 – one exam and 1 pair of glasses every year

The date of their last exam and pair of glasses will be listed in the limits segments in TMHP.

MEDICAID QMB DOES NOT COVER REE OR GLASSES, ONLY MCR COINSURANCE.

Medicare

Medicare will cover **ONLY** medical vision visits, subject to coinsurance. Routine vision visits or contact lens exams will go the patient's secondary payer if applicable or will be the patient's responsibility.

- Medicare/Ryan White client – Charge the Medicare coinsurance for the medical visit and the Ryan White copayment for the routine visit. Create/apply the Ryan White case to Dicks appointment
- Medicare/MQMB client – No copayment is collected. Create/apply MQMB case to all routine visits.
- Medicare/Self Pay client – Collect coinsurance as usual for medical visit. Collect Self Pay or Sliding Scale payment for routine visit. Create/apply Self-Pay/Sliding Scale case to routine appointments.

Ryan White

Ryan White will cover both the routine eye exam and medical vision visits for patients <300% of FPL. Ryan White will **NOT** cover glasses or contact lens fittings. Ryan White patients are provided with one pair of free glasses every two years, regardless of FPL. The vision staff is to determine eligibility for courtesy glasses. Ryan White patients only pay ONE copayment if BOTH visits are covered under Ryan White for the cost of BOTH visits and glasses if visit is scheduled on the same day.

Charge the usual Self Pay or Sliding Scale fees.

Commercial Insurance (BCBS, Aetna, Humana, UHC Private, etc.)

Medical Vision

When calling to verify for an Ophthalmology visit, you will ask for Specialist office visit benefits. *BCBS requires that you give **the Ophthalmologist's NPI** when verifying, or they will quote you out of network benefits.

Routine Vision

Some of these policies will have a routine eye exam available through the medical piece of their insurance. Deductibles and coinsurance may apply (usually only if Dr. Dicks is an out of network provider). Most of these plans will have **vision vendors** to handle routine eye exams, contact lens fittings, and discounts on glasses. We are out of network with most of these vendors.

You can call to verify if the client has OON benefits. When asking for routine vision benefits from the customer service representative ALWAYS ask if the eye is exam is handled through the medical policy or through a vendor. If the representative says that the eye exam is ONLY covered as a screening with a routine preventative visit, or that refraction is NOT included, then the visit is NOT covered. Very rarely, if ever, will contact lens fittings or eyeglasses be covered through the medical policy. If a representative tells you that glasses or contact lens fittings are covered and gives you an allowance amount, call back and speak to another representative to verify.

When a patient has a non-contracted policy and no out of network benefits, has already used their routine vision benefit, or has a discount plan, the cost of the exam becomes the patient's responsibility. Ryan White will not pick up the cost of these services since they do have coverage. As a courtesy, call the patient to let them know that we are not in network, their benefits cannot be used here, or that they have already used their benefits. Inform them of the amount that they will owe at the time of the visit.

Star, Star Plus, & CHIP

Some insurance plans use vision vendors for routine and medical vision. Please see chart below for more information. You must verify if services are covered, if benefits are available, and if authorization is required. Create cases for alternate carriers and apply them appropriately.

Psychiatry

For all commercial plans (Aetna, BCBS, Cigna, Humana, etc.) require a call to obtain benefit information. Some plans will use vendors for BH (Value Options, Optum, Magellan, etc.) for which you need to apply cases and pre-authorization may be required.

Ryan White Grant

Ryan White is billable for nutritional counseling and nutritional supplements. If a patient is on the schedule for Nutrition, follow the "*Ryan White Verification*" process under the Primary Care Verification section.

- Copays do not apply to nutrition visits.
- The patient is allowed 12 counseling visits per contract year by a licensed dietician.

- The patient may receive up to a 90-day supply of supplements on a single visit.

Dental Verification

Dental Vendor for Medicaid patients can be found on TMHP. For all commercial plans (Aetna, BCBS, Cigna, Humana, etc.) require a call to obtain vendor information. Once vendor is identified create/apply case with dental vendor.

All Other Payers

All others are not billable and do not need verification.

III. SLIDING FEE DISCOUNT PROGRAM POLICY & PROCEDURES

Related Form: Sliding Fee Checklist, Patient Responsibility

Related Policy: Fee Scheduling Establishment and Maintenance

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

Sliding Scale is a discount program that is provided to all eligible clients based on the patient's ability to pay. Ability to pay is determined by the household income and family size.

It is Coastal Health & Wellness' (CHW's) policy to establish a sliding fee discount schedule based on a patient's ability to pay for all services within the health center's approved scope of project regardless of the mode of delivery i.e., Column I, II, or III of Form 5 for which there is an established charge. The SFDS is established and implemented to ensure that uniform and reasonable fees and discounts are consistently and appropriately applied to all health center patients to address financial barriers to care. Eligibility for the SFDS will be based on income and family size and no other factors.

1. CHW provides access to services without regard for a person's ability to pay for such services. The Clinic has established a Board-approved sliding fee discount program in accordance with current requirements.
2. The Board of Directors shall examine the nominal fees about whether they are a potential barrier to care. The quarterly patient satisfaction survey findings shall be shared with the Board of Directors as one means off assessing the nominal fee.
3. A full discount to individuals and families with annual incomes at or below those set forth in the most recent *Federal Poverty Guidelines (FPG)* [100% of the FPG], except that nominal charges for service may be collected from such individuals and families where imposition of such fees is consistent with project goals; and
    a. No discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines [200% of the FPG].
    b. CHW's nominal fee for medical visit for patients at or under 100% of FPG is $35.00.
4. CHW will update the Sliding Fee Discount Schedule related to changes in the Federally Poverty Guidelines. Federal Poverty Guidelines are updated by the Department of Health and Human Services annually and it is the goal of Monarch to update their Sliding Fee Discount Schedule within three months of the release of the new guidelines. The review will conclude with the board providing guidance and direction to the CFO to ensure that this and other related policies and / or operating procedures are updated appropriately.

5. It is the policy of CHW to screen all patients to determine qualification for the center's sliding fee discount program.[1] To maintain its compliance with the requirement to serve all patients regardless of ability to pay, a center must also offer a sliding fee schedule of discounts to patients who are uninsured for all services or the particular service they seek; also, for underinsured patients, the center should apply the sliding fee discount to co-pays for covered services.
6. CHW utilizes multiple methods for informing patients of the availability of the SFDS in languages and at literacy levels that are appropriate for the patient population (currently in English and Spanish). The methods used to inform patients are as follows:
    a. Signage at all desks
    b. Brochures that are given to patients during initial visits
    c. CHW's website
7. CHW allows for a process and criteria for waiver of fees and nominal charges on a case-by-case basis.
8. CHW will prepare a schedule of fees to charge that allows for a "sliding fee discount" that will assure:
    a. That full fees to any patient with an annual income greater than 200% of the amount set forth in the Federal Poverty Guidelines (FPG)[3] and gives a full discount for those making less than 100% of the amount set forth in the poverty guidelines.[4]
    b. Allows for a nominal fee may to be charged to assure access.
    c. Includes reasonable efforts are made to collect payment from self-pay patients.[5]
    d. After the collection process has been followed, the uncollected amount should be written off to avoid the appearance of collectable accounts receivable that overstate the center's financial assets.
9. CHW will provide notice using more than one method to patients of the sliding fee discount that is appropriate for the language and literacy level of patients. Such notice should include what services outside the center's scope of project the patient may be billed for separately by the center or a third party.
10. CHW will review what other government or community programs that they may participate in to provide the following services to clients who are not necessarily eligible for Medicaid or CHIP:

1) See 42 USC 254b(k)(3)(G), 42 CFR 51c.303(f), and the HRSA Health Center Site Visit Guide, especially pages 13-15. Covering costs should include covering a margin. The Medicare and Medicaid fee schedules offer guidance.
2) Id. Please note that centers may not automatically apply discounts or waivers to Medicare co-pays, but must review whether the patient is eligible on a case by case basis. See 42 CFR §1001.952(k)(2).
3)The Federal Poverty Guidelines are here and usually updated in the first quarter of each calendar year.
4) See 42 USC 254b(k)(3)(G), 42 CFR 51c.303(f), and PIN 2014-02.
5) See 42 USC 254b(k)(3)(F), 42 CFR 51c.303(g).

primary healthcare (PHC), family planning, breast and cervical cancer treatment, HIV/STD treatment, services for children with special healthcare needs and school-based services.[2]

11. Not all services are covered under the sliding fee program. Medical services provided "in-house" are eligible for a sliding fee discount. "In-house" refers to medical services provided at the clinic such as some labs, EKG's, some immunizations, and office visits. All Non-Vaccines for Children (VFC) or Non-Adult Safety Net (ASN) immunizations and/or injections, in addition to administration cost, and in house testing and procedures (e.g., INR (coagulation), A1C, biopsy, sutures) as well as IUD's, Birth Control Implants, and durable medical equipment are not included in the encounter rate and uninsured patients will be responsible for payment for these services/supplies.
12. Current Dental patients who qualify for the sliding fee discount program are required to pay for any associated lab costs for certain designated procedures unless they are above 200% of the federal poverty level and required to pay full charges

Procedures

1. Staff will assure that any fees or payments required by the center for health care services will be reduced or waived to assure that no patient will be denied such services due to an individual's inability to pay for such services.
2. The components of the sliding fee discount schedule are as follows:
    a. Definition of Income and Family Size
    b. Documents required to be provided by patients to support definition of income
    c. Determination of eligibility guidelines
    d. Structure of the Sliding Fee Discount Scale
    e. Definition of Income and Family Size Documents required to be provided by patients to support definition of income
    f. Determination of eligibility guidelines
    g. Structure of the Sliding Fee Discount Scale
3. CHW defines Income and Family Size as follows:
    a. **Income:** Money received by a household head and/or spouse/significant other for money received, especially on a regular basis, for work or through investments.
    b. **Family:** A family is defined as a person living alone or a group of two or more persons related by birth, marriage (including common-law), or adoption, which reside together and are legally responsible for the support of the other person. Unborn children are also included in family size.
    c. **Family Size:** The number of individuals in the family.

[2] Texas Department of Health & Human Services https://yourtexasbenefits.hhsc.texas.gov/programs or Texas 211 https://www.211texas.org for more information about programs.

4. Acceptable forms of support for documentation of Income are as follows:
    a. Self-Declaration (if applicable)
    b. Check stubs for the current month (if paid weekly last 4 paystubs, if paid bi-weekly last 2 paystubs, if paid monthly last 3 paystubs)
    c. Current Tax Return or W2 Forms
    d. Employment Verification Form (EVF) or Letter from Employer
    e. Unemployment Benefits or Wage Detail from Workforce (if unemployed and not receiving unemployment)
    f. Assistance Statement Verification (Supporter Statement that indicates unemployment and/or zero income) Retirement or Social Security Benefits Letter
    g. Child Support
    h. Public Assistance Verification letter
    i. Letter from Homeless Shelter attesting income/no income
5. CHW's patient eligibility process for sliding fees is based on the following:
    a. Patient eligibility will be updated annually, and patients will be notified of their benefit term at the time of the application. CHW has records of assessing/re-assessing patient income and family size annually, except in situations where a patient has declined or refused to provide such information for further enrollment.
    b. CHW has supporting processes/operating procedures in place for assessing and verifying income and household size for patients that it uses to train personnel on the program and
    c. The SFDS is structured in a manner that adjusts based on a patient's ability to pay.
    d. Patient's eligibility is determined by FPL % based on the household's income and family size, using the current Poverty Level Guidelines showing income ranges and categories.
    e. Individuals and families with incomes at or below 100% of the FPG pay a "nominal charge." Individuals and families with incomes above 100% and at or below 200% of the FPG are charged amounts that are tied to graduated income levels. CHW has a minimum of 3 discount pay-classes above 100% and below 200%.
    f. Individuals and families with incomes above 200% of the FPG are not eligible for sliding fee discounts and thus are charged a full fee for services. These charges may be reduced by other funding sources that contain terms and conditions relating to specific services.
    g. CHW is permitted to utilize multiple sliding fee discount schedules. All schedules should be structured using the criteria previously mentioned in this section. Each Sliding Fee Discount Schedule will be based on either broad service types (such as medical and dental), distinct subcategories or service types (such as preventive dental and additional dental services), and/or on service delivery method (such as services provided by CHW

directly vs. provided through a formal written contract). All sliding fee discount schedules by CHW will be approved by the Board of Directors annually.

h. CHW will include information on every sliding fee discount schedule that indicates if a patient will be financially responsible for supplies that might be used during the provision of services. Certain services including contact lenses, vision hardware are examples of fees that are not included in the sliding fee discount. Some of these services may require payment in advance of ordering. Under CHW care card services, an "immediate medical need" will be determined and assessed by the provider or department providing the service to the patient. More extensive treatments or procedures may also be excluded.

6. Patients with Third Party Coverage

   a. It is CHW's Policy that the charge for each SFDS pay class is the maximum amount an eligible patient in that pay class is required to pay for a certain service, regardless of insurance status.

   b. If an insured patient qualifies for the sliding fee discount schedule, the patient will be placed on the sliding fee discount schedule and charged the lesser of the amount due per the sliding fee discount schedule or the co-pay, deductible, etc.

   c. CHW does and cannot require individuals to enroll in public or private insurance and this is not a factor when determining eligibility. However, it is CHW's Policy to educate patients based on their eligibility for public or private insurance for which they might qualify.

7. Services provided via formal referral arrangement

   a. For services provided through a formal referral arrangement (Form 5A, Column III), CHW will ensure that the fees for such services are either discounted as described in paragraph 5, sub-section 4 or discounted in such a manner that:

      i. Individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the FPG receive an equal or greater discount for these services than if CHW's SFDS were applied to the referral provider's fee schedule, and Individuals and families at or below 100 percent of the FPG receive a full discount or a nominal charge for these services.

8. Patients who refuse to pay will be offered one of the following 3 options: sliding fee discount, a payment plan, or a grace period (See *Refusal to Pay Policy & Procedures*).

9. The 3-month CHW Presumptive Sliding Fee Eligibility program documentation deadline period shall be extended in case of declaration of emergencies or disaster by the national, state, or local officials, as well as reviewed based on case-by-case situation to reduce barriers to care. There will also be an extension of presumptive sliding fee discount eligibility deadline under special circumstances.

10. **Annual Audit:** As a component of CHW's annual financial audit, the sliding fee discount program audit will be performed by External Auditors each Fiscal Year. The audit will include the following:

a. A random sample of sliding fee applications will be selected from patients see during the audit year.

b. The auditor reviews all accompanying documents for accuracy and completeness.

c. The approval/disapproval decision and the selection of the sliding fee discount category are also reviewed for accuracy by auditor.

d. Any necessary sliding fee discount corrections will be documented and included in the following meeting of the Continuous Quality Improvement (CQI).

Patient Responsibilities for Sliding Fee Discounts

1. To satisfactorily comply with all regulations and policies, CHW's patients have responsibilities to cooperate with the SFSD requirements:

    a. They will need to complete the sliding fee discount application (Application for Health Care Assistance)

    b. Provide requested personal information as listed under the "clinic responsibilities" to the Clinic. Failure or denial to provide all required information will result in denial of eligibility.

2. If supporting document is not available or is insufficient to determine eligibility, the patient will be placed on a 3-month Presumptive Eligibility. The goal of Presumptive Eligibility is to reduce barriers to immediate care for patients and to ensure patient have enough time to present required documentation for Sliding Fee Program. If the patient does not present the appropriate documentation to CHW within the 3 months, he/she will not be eligible for sliding fee discount program and will automatically be assigned standard office visit fee until the following year.

3. CHW will for assess/re-assess all patients for income and family size consistent with board-approved sliding fee discount program policies annually. This assessment will be documented in the practice management system. Patients are required to provide updated information at that time.

IV. FEE SCHEDULE ESTABLISHMENT & MAINTENANCE POLICY & PROCEDURES

Related Form: Master Fee Schedule Report

Related Policy: Sliding Fee Schedule Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

1. It is the policy of Coastal Health & Wellness (CHW) to prepare a schedule of fees for the provision of its services consistent with locally prevailing rates or charges and that is designed to cover its reasonable costs of operation. The fee schedule will be developed based off the services approved by the CHW Board of Directors.
2. CHW's fee schedule is intended to generate revenue to cover the costs associated with providing services and assist in ensuring the financial viability and sustainability of the health center. Additionally, the fee schedule will be CHW's basis for seeking reimbursement from patients as well as third party payers. CHW's fee schedule will address all required and additional in scope services.
3. It is CHW's Policy that fees will be set to cover reasonable costs and will be consistent with locally prevailing rates or charges for the service. CHW will perform an analysis to associate costs with the provision of services for consideration in the pricing analysis. Locally prevailing charges will be analyzed through a possible review of the following:
    a. Commercial sources fee analyzer utilizing an adjustment corresponding with a geographic index
    b. Medicare Physician Fee Schedule available through CHW's MCR intermediary
    c. Private providers* in CHW's community or other, similarly situated communities
    d. Other information available
4. It is the policy of CHW to have a formal review of fees performed by an independent, outside source every two to three (2-3) years. CHW will perform the analysis internally as codes are added or modified throughout the year.
    a. Each CPT and HCPCS code entered into CHW's system, manually or via yearly coding updates, is assigned a fee.
    b. CHW uses various software products to determine its fees (which may include, but is not limited to, Physician's Fee Reference software for coding pricing, Wasserman Medical Publishers, LTD and Centers for Medicare and Medicaid Services National Physician Fee Schedule RVU data.
    c. CHW analyzes its fees using commercially available billing information that considers the geographic areas that CHW serves.

* CHW will seek the advice of private legal counsel when gathering fee-related information from other providers to ensure that it does not violate anti-trust regulations.

Procedures

1. After the analysis of cost and locally prevailing charges above, CHW will decide on an appropriate pricing strategy for the fee schedule given the patient population and current reimbursement environment. CHW will document this analysis to provide support in the event of an inquiry by third parties.
2. If the board of directors approves of the provision of out-of-scope services provided by an entity other than CHW (such as a hospital) CHW will inform patients that they may be billed for the services/goods by another entity in accordance with the other entity's policies and procedures.
    a. Additional supplies non-incident to the service are priced via alternate method. Patients will be notified of additional fees in advance.
3. CHW has elected to acquire, purchase, and facilitate access to equipment, supplies, and pharmaceuticals that are related to but not included in, the services provided by CHW as part of prevailing standards of care (examples would include eyeglasses and dentures). CHW chooses to do so to improve access to these items as a means of reducing barriers to care and improving health outcomes for its patient population. Revenue generated from these charges will be used to further the project objectives.
    a. CHW will determine a charge for these items by analyzing its costs and the needs of the target population. CHW will, at its discretion, determine how to charge its patients for such supplies or equipment (for example, flat discounts, at cost, or on the sliding fee scale). Charge information for these items will be presented to the Board of Directors for approval. Prior to the provision of a service, patients will be informed by CHW of the following:
        i. When supplies or equipment related to a given service will result in separate charges from the service
        ii. The total amount of out-of-pocket costs for these supplies or equipment
        iii. Available payment plans
4. The Practice Management System will be updated annually based on release of new CPT codes, updated cost reviews, and/or carrier reimbursement reviews.

References or Regulations

- Centers for Medicare and Medicaid Services
- Physicians Fee Reference

V. PAYMENT POSTING POLICY & PROCEDURES

Related Form: Master Fee Schedule Report

Related Policy: Charge Entry Policy, Billing and Collections Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

1. Coastal Health & Wellness (CHW) assures the appropriateness of applying payments to CHW patient accounts and making the appropriate adjustments in the practice management system (PMS).
2. It is CHW's policy to post all payments into the practice management system appropriately and in a timely manner. All payments should be posted within 5 business days upon receipt in a postable format.
3. All Patient and third-party payments will be posted and managed in the electronic PMS.
4. When possible, all electronic payments should be posted electronically. Only those carriers that do not allow electronic reports will continue to be posted manually.

Procedures

1. CHW accepts payments remitted and transferred directly from third-party payers by all payers offering electronic remittance advice (ERA) and electronic funds transfer (EFT). Remittances are accepted when available from the payer but are not posted until CHW accounting department staff confirms the remittance total to the funds transferred.
2. CHW accepts all non-electronic payments, including non-electronic third-party payer and patient checks, managed through CHW accounting department.
    a. Payments are tracked and logged in accounting.
    b. Payments received are posted based on deposit date.
3. All staff balance the batches assigned to them each day.
4. A transaction code is posted to the charge level on the account to identify the type of rejection.
5. Correspondence is relayed to the Billing staff member assigned to working on account follow up.
6. Health Center staff members posting payments are responsible for accurate posting on a line-item basis.
7. Health Center staff members who post payments are responsible for the transfer of the account balance to the patient or to secondary or tertiary payers (and manually or electronically mark the primary explanation of benefits unless the claim is an automatic crossover by the primary payer).

8. Payment posting is monitored closely to ensure timeliness and accuracy, as well as to identify opportunities for improvement.
9. Correspondence, including rejections, with no payment attached is flagged manually or electronically.
10. A summary of all batches posted are reconciled to the daily deposit and provided to the business office manager or designee.
11. The deposit date and posting date should match. These dates are sent with the deposit batch from accounting.
12. The batch number will include the deposit date for tracking purposes.
13. Payments received over the phone paying via credit or with debit card will be charged and posted to the patient account by the medical records specialist or designated personnel from other departments outside of billing department.
14. Payments received thru mail will be posted by the patient support specialist and reconciled and deposited by finance administrative assistant.
15. Payments will be posted to the oldest date of service with an outstanding balance unless the patient specify what date of service the payment is for.
16. Payments received at time of Service will be posted to the patient account by the patient support specialist.
17. Payments from program or third-party funding sources will be deposited by the finance administrative assistant and posted by biller and/or payment posting specialist. Remittance advices will be posted to the encounter by the payment posting specialist for reconciliation of patient accounts. The posting will occur within 7 days of receipt. Payments will be reconciled monthly based on deposit reports from the finance department.

**Claim Status should be updated to reflect any claim that is not paid in full or needs additional follow up. This is the primary search method for billing staff working accounts and is imperative to the process.

Unidentified/Incentive/Capitation Payments

1. CHW may receive payments that cannot be directly linked to a client's chart.
    a. Those payments will be posted to the unidentified payments dummy account. These payments will be referred to the AR team for research and resolution.
2. CHW may receive incentive payments that are not directly linked to a client's chart.
    a. Those payments will be posted in the incentive payments dummy account.
    b. Incentive payments will be posted according to date of receipt.
3. CHW may receive capitation payments that cannot be directly linked to a client's chart.
    a. Those payments will be posted in the capitation payments dummy account.

b. Capitation payments will be posted according to date of receipt.

4. Periodically, the business office manager or designee will select a sample of remittances from each payer and compare the payments and contractual adjustments indicated on the remittance to the payments and adjustments posted in the practice management system. Any discrepancies between information on the remittance and payments and adjustments posted in the practice management system will be addressed by the business office manager or other supervisor and the staff person responsible for posting the payments and adjustments.

Small Balances Write Offs

1. Patient small balances will be automatically written off after 180 days.
2. Small balances are amounts equal to or less than $5, which will cost more to bill for the balance than the value of the balance.
3. If the account balance is less than or equal to $5, is more than 180 days old, and there are no insurance due balances, the account balance is written off. These transactions are marked with the applicable “small balance write off” code.
4. On a monthly basis, a report is generated that identifies accounts that meet these criteria.

VI. CHARGE ENTRY POLICY & PROCEDURES

Related Form: Master Fee Schedule

Related Policy: Payment Posting Policies, Billing and Collections Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

1. It is the policy of the Coastal Health & Wellness (CHW) to capture the services performed for a patient in an accurate and timely manner.
2. It is the policy of CHW to facilitate a timely and efficient billing and collections process. To that end, CHW complies with predetermined lag times for key billing processes, including submissions of claims to third-party payers in a timely manner as a courtesy to patients and to receive prompt payment for services rendered.
3. Charges for services rendered should be accurately posted by Health Center staff within 5 days of the date of service.
4. CHW will take the appropriate steps to capture services performed for a patient in an accurate and timely manner. The charges are captured via electronic medical record system or paper superbill.

Procedures

Office Procedures

1. CHW providers are responsible for submitting all procedure and diagnosis codes on the same day when rendering services in the office, and 72 hours for services rendered out of the office.
2. Charge capture includes the following information for every patient encounter regardless of the site of service. (Note the practice management system provides several of these elements electronically.)
    a. Patient name
    b. Patient identification
    c. Date of birth
    d. Attending provider
    e. Place of service
    f. Date of service(s)
    g. Procedure code(s)
    h. Diagnosis code(s) – appropriately linked to procedure codes, if applicable
    i. Additional information as needed to process the charge

j. Referring physician, if applicable

3. The provider documents all services rendered to the patient in the electronic medical record.
4. The provider completes charge documentation at the time the service is rendered.
5. Diagnosis "rule outs" are not permitted. A diagnosis must be made and coded based on information available and symptoms presented.
6. Providers must match procedure codes to the appropriate diagnosis codes using a numeric method and/or via the methodology provided by the practice management system for linking diagnosis codes when multiple procedures codes are used.
7. Providers are responsible for documenting and coding all procedure and diagnosis codes into the EHRS or on n the charge ticket. Procedure and diagnosis codes are created for each unique patient visit.
8. Encounters or charge tickets with incomplete or illegible charge data are flagged or returned to the originating provider for completion to ensure expedient billing and collection.

Billing Staff Procedures

1. Timeliness and accuracy of charge coding and medical record documentation are regularly reviewed. Every effort is made to eliminate errors in registration, procedure and diagnosis coding and charge entry to ensure timely reimbursement.
2. Charges are posted in the practice management system within one business day of being received at the business office, through the electronic medical record or data entry by a staff member from a paper charge ticket.
3. Using available electronic or manual tools and resources, CHW staff is responsible for reviewing and editing charges before they are submitted.
    a. During the review process, any discrepancies are resolved immediately.
    b. If necessary, the provider rendering the service for which the charge is being billed is contacted in person, via an internal email communication regarding the charge.
    c. Providers have two business days to respond to questions about charges.
    d. Charge edits are resolved within three business days.
4. CHW staff submits prepared claims within two business days of charge entry.
5. CHW staff monitor the period of the claim's submission to payment by the payer.
6. The lag times for the following key processes are monitored by Billing staff. Outliers are reported to the service line directors. The key processes are:
    a. Date-of-service to date-of-charge submission versus documentation and coding must occur within a reasonable timeframe.
    b. Date-of-charge submission to date-of-claim submission
    c. Date-of-claim submission to date-of-payment by third-party payer

d. If applicable, additional key processes will be identified and monitored by the business office manager and/or executive team or designee.

VII. CLAIMS SUBMISSIONS POLICY & PROCEDURES

Related Form: Master Fee Schedule

Related Policy: Payment Posting Policies, Billing and Collections Policy, Charge Entry Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

It is the policy of Coastal Health & Wellness (CHW) to conform to industry standards to assure prompt billing and collections from insurance carriers and patients. Billing of claims are processed and followed up in a timely manner

Procedures

1. Following the edit process, clean claims are sent electronically real time or by the end of the business day.
2. Exception reports generated from the submission are worked on a same-day basis.
3. Claims are not suspended / held unless necessary.
4. Claims placed on hold status and monitored by the billing directors to ensure suspended/ held claims are resolved expediently.
5. CHW submits secondary claims in the event a patient maintains a secondary insurance policy and the primary insurance carrier does not pay the full amount of the charge. The secondary insurance carrier is billed for the remainder of the balance CHW makes best efforts to work with payers to crossover secondary claims automatically. If not, the primary explanation of benefits (EOB) is flagged manually or electronically and submitted to a CHW staff member to bill the secondary insurance carrier.
6. Within 24 hours of notification of responsibility of the secondary payer, the secondary claim(s) are submitted.
7. The full balance of primary and secondary claims submitted to third-party payers with whom the CHW does not participate may be transferred to patient responsibility.
8. For services covered under a capitated plan, charges are automatically adjusted by the practice management system. If a patient receives a service for which the patient is covered, but which is not included in the capitation agreement, a claim is sent to the third-party payer.

VIII. BILLING RECORDS RETENTION POLICY & PROCEDURES

Related Form: Release of Medical Records, Patient Financial Policy

Related Policy: Medical Records Policies

Responsible Department: Billing Department

Board Approval Date:

Policy

It is the policy of Coastal Health & Wellness (CHW) to maintain original billing and financial documents in accordance with CHW medical records retention policies.

Procedures

Confidentiality

1. Patients as well as the billing staff will be made aware that the electronic medical record and the information contained within are to be held in strict confidence. This will be done by providing a written privacy policy to all patients (or their legal guardian) and posting the privacy policy in a public area within CHW. HIPAA training upon hire and ongoing annual HIPAA refreshers will make the clinic staff aware of this.
2. A patient must give written permission for the release of medical information for billing purposes. A parent or legal guardian must supply this permission for a minor. The patient Financial Policy will be signed to give permission to release records as needed for billing purposes. The only exception to this is when records are released from provider-to-provider for continuing medical care for the patient.

Record Release and Retention

1. Original billing records such as EOBs, Patient Financial Statements, Signed Sliding Fee documentation shall be maintained in HIPAA secure storage in accordance with CHW medical records retention policies.
2. A billing Manager will review documents and approve the release of medical records to support patient charges or insurance or regulatory audits prior to the release of records.

IX. BILLING & COLLECTION POLICY & PROCEDURES

Related Form: Patient Refund Request Form

Related Policy: Medical Fee Waiving Policy; Refusal to Pay Policy, Sliding Fee Adjustment Policies

Responsible Department: Billing Department

Board Approval Date:

Policy

1. It is the policy of Coastal Health & Wellness (CHW) to conform to industry standards to assure prompt billing and collections from insurance carriers and patients. Billing processes including but not limited to assignment of codes, electronic submission of claims, appeals for denied claims as well as collections processes are processed and followed up in a timely manner.
2. Although we do not utilize an outside collection agency, collection efforts are continued for a minimum of 120 days. These are conducted in an efficient, respectful, and culturally appropriate manner, that assures that procedures do not present a barrier to care, and patient privacy and confidentiality are protected throughout the process. At 120 days with no payment or activity on account the balance will be adjusted following the guidelines for aging of patient accounts.
3. It is CHW's policy to maximize revenue from public and private third-party payers and make reasonable efforts to obtain reimbursement from those parties, including public health agencies.
4. It is the goal of CHW to submit clean claims to third-party payers in a timely manner as a courtesy to patients and to receive prompt payment for services rendered.
5. CHW will participate in Medicaid, Medicare, CHIP, and as appropriate, other public and / or private assistance programs or health insurance. CHW has procedures in place to educate patients on health insurance options available to them based on their eligibility for insurance and / or related third party coverage.
6. All reasonable efforts to secure payment from patients for services rendered are made by billing and front desk to collect the payment in full. Payment plans are acceptable and offered when appropriate. Collection attempts are made and continued, and additional meeting with eligibility to determine if additional financial hardship is needed.
7. To assure data integrity, CHW will perform daily balancing and full monthly close procedures as soon as reasonable after the last day of each month.

Procedures

Patient Payments and Collections

1. Patients will be offered screening for program eligibility and/or sliding fee program.
2. Dues from insured patient (co-payment, co-insurance and/or deductible):

a. The copayment, co-insurance or deductible is the minimum amount expected for the services provided and are requested at each visit. No patient will be refused service based on inability to pay.

b. At each visit, the patient support specialist will notify the patient of the current amount due and any outstanding balance(s) and will attempt to collect on the balance(s), remind the patient of their financial obligation, and/or inform the patient of the financial arrangement option(s).

3. Dues from self-pay patient:

    a. Patients are expected to make a payment before seeing the provider. The patient support specialist will request the payment upon check-in. No patient will be refused service based on inability to pay.

    b. At each visit, the patient support specialist will notify the patient of the current amount due and any outstanding balance(s) and will attempt to collect on the balance(s), remind the patient of their financial obligation, and/or inform the patient of the financial arrangement option(s).

4. Patients who are unable to pay for their services on the day of the visit should be referred to *Refusal to Pay Policy and Procedure* to establish a financial arrangement option. Payment arrangements can be initiated by patient support specialist and must be approved by site lead and above at the clinic. The payment arrangements are only available on accounts with balances greater than $25.00.

5. A statement will be sent to the patient with outstanding balance due on their patient account. The patient has an option to pay by cash or with credit card at one of CHW location, mail in check or credit card information.

6. CHW is committed to assuring that all reasonable collections efforts are made prior to writing off unpaid balances to bad debt. A minimum of 3 statements will be sent to patients with balances over $25.00.

7. CHW provides education to patients on insurance and, if applicable, related third party coverage options available to them.

Aging and Write-off

1. Accounts with remaining balances (positive or negative) of less than one ($1- $10) dollars may be written off within a reasonable amount of time at billing and insurance verification coordinator discretion.

2. All self-pay balances and patient owed after insurance paid that are greater than 180 days and/or 3 statements have been mailed out shall have their account verified that they have at least 3 statements, then the account shall be written off as bad debt.

3. Accounts with balances greater than 365 days and in a bad debt status will be adjusted off an account as uncollectible.

4. To be considered for write-off, the billing department must be able to demonstrate that adequate steps were taken to collect the amount due.
5. Anything found questionable must have approval from the Chief Operating Officer.

Patient Complaints about Patient Fees

1. The patient support specialist should explain the billing process to the patient.
2. If the patient's concerns are not adequately addressed, the patient support specialist should refer the patient to site lead.
3. Site lead will use their discretion in resolving the patient concern. Patient concerns and resolutions must be note on the EHR. Potential resolutions include, but are not limited to the following:
    a. Accepting partial payment for services that day and defer remainder of the balance to the next visit.
    b. Initiate arrangement for payment plan.

Refunds/Credits

1. It is the goal of CHW to return all monies that are not due to the Health Center. These may include overpayments from patients or third-party payers. CHW is committed to complying with state and federal laws, as well as to minimize the impact that refunds have on receivables (i.e., refunds negate receivables) and management reports regarding business office performance.
2. Overpayments are flagged at the time the payment is posted and the ticket is moved into overpayment status.
    a. CHW billing staff works these refunds ensuring the overpayment status if appropriate.
    b. The staff member completes a Refund Request Form to request the refund check be processed.
    c. A thorough review of the account is conducted to determine the cause of the credit balance.
    d. If a posting error caused the credit balance, a refund is not made.
    e. Thorough documentation of the refund is placed in the notes section of the patient's account.
3. In addition to proactively refunding credits created during the posting process, the billing department is responsible for refunding outstanding credits.
    a. The accounts should be reviewed thoroughly.
4. Credit invoices are identified and refunded to the patient, guarantor, or third-party payer within 30 days.
    a. Any credits identified that can be transferred to another outstanding invoice are done within 30 days of creation date.
    b. The oldest credits should be processed and refunded first.

5. If a credit balance occurs for a guarantor with multiple patients on the account and a debit balance remains on the total account, the credit is posted as an open balance payment.
6. Refunds are posted to the patient's account when the refund check is issued.
7. Requests for refund checks are submitted to the business office manager or designee in writing or via internal email on the Refund Request Form and require the designated supervisor's signature

Insufficient Fund Checks and Unredeemed Refund Checks

Insufficient Fund Checks will be handled by the finance department. Refund checks written to patients that are not redeemed within 90 days, the finance department will reach out to the patient. If the patient is not reachable within a reasonable time period, the check will voided and either leave the credit balance on the patient account or report to the Texas State Comptroller as unclaimed property by the finance department.

Changes in Assigned Billing Codes

The Billing Department does not change codes other than written procedure, or with permission from the attending provider.

If provider clarification is needed either because of an internal chart review or at the request of an insurance carrier, communication from billing leadership regarding the requested clarification will be made to the rendering provider. The communication will request appropriate documentation/charting and provide a clear, concise request for the clarification needed.

Any change or update to codes will have the reason for the code change appropriately documented and will comport with CHW's PMS procedure and appropriate coding guidelines (see AAPC and AHIMA standards). The reason for code changes will be appropriately documented.

Denials/ Rejections

All claim rejected by clearinghouse must be identified, corrected, and resubmitted within 5 business days. All claim denied by insurance should have valid reason behind the claim denial and appropriate action to be taken within reasonable time period. Below are the most common denial reasons:

Claim denied for incorrect information.

- Incorrect provider information.
- Incorrect coverage information.
- Lack of information.

Claim denied as inclusive with the primary procedure

Some service covered with primary procedure; hence we need to write off the claim balance after primary CPT paid. This is important to watch for claims that go out with both a T1015 and a CPT code. If T1015 pays the encounter rate and the visit is paid in full, any balance should be adjusted off appropriately. However, if CPT is payable separately - will resubmit the inclusive procedure with modifier.

Claim denied as services not provided or authorized

- File the claim along with appropriate authorization#.

- If we do not have authorization #, sometimes we can appeal the claim along with necessary medical document. Confirm if the visit had an authorization.
- If no authorization is on file, contact carrier and request retroactive authorization; resubmit claim.
- If no authorization can be obtained, adjustment should be made.

Claim denied because of incorrect medical coding

- Billing department email list of charts to be corrected to CHW provider. After the charts being corrected, billing staff reviews the charts to confirm correct information and resubmit/ appeal the claim with correct diagnosis (DX) and CPT.

Denied insurance claims due to invalid CPT code

- The claim should be filed with valid CPT. The billing department needs to contact EHR administrator to update the database if need.

Claim denied because primary insurance changed

- File the claim to patient primary insurance if additional coverage is on file.
  - Check copy of the insurance card to see if additional coverage is listed (for example – TCHP will list primary coverage if it exists). Update registration, re-file claim.
  - If we don't have patient primary insurance details, we need to call the patient and get the insurance information. Verify new coverage, update registration and re-file appropriate claims.
  - If patient has no coverage, update visit to self- pay. Balance will be posted to patient's account. After the statement is sent out, the patient can make payment arrangements or refer to eligibility to verify for additional payer sources.

Claim denied for coordination of benefits

- Patient needs to update the COB information to insurance. If patient has more than one insurance, patient need to call the insurance and inform which insurance is primary and secondary for patient. Update registration; refile claims appropriately. Check copy of the insurance card to see if additional coverage is listed (for example – TCHP will list primary coverage if it exists). If we can confirm term date with patient, we can contact carrier with term date; update registration; refile claims appropriately.

Claim denied for maximum benefits reached.

- File the claim to secondary along with denied EOB. If patient does not have secondary insurance, update visit to self- pay. Balance will be posted to patient's account. After the statement is sent out, the patient can make payment arrangements or refer to eligibility to verify for additional payer sources.

Claim denied for retroactive termination date

- Contact the patient to verify updated coverage. If no coverage in place, change financial class to self-pay and invoice the patient. Payment plan option is available.

Claim denied for invalid referral number

- The claim should be filed with valid referral number. If we do not have valid referral number, we can request the same from referring doctor and refile the claim with valid referral. (May apply for specialty services where patient has another PCP).

Denied benefits is not covered by the patient's plan

- Update visit to self-pay. Balance will be posted to patient's account. After the statement is sent out, the patient can make payment arrangements or refer to eligibility to verify for additional payer sources.

Claim denied dates of service over filing limit

- Claims should be filed within the filing limit according to CHW guidelines. If the denial for TFL is received, we can appeal the claim with TFL proof. Confirm filing / batch information and resubmit claim with proof of timely filing. If no proof of timely filing exists, submit to billing supervisor for adjustment.

Claim denials bundling inclusive

- Needs to differentiate the service by using appropriate modifier and DX code.

Claim denied primary paid in full

- Need to adjust the claim balance. (T1015 plus CPT code – adjust off once full encounter rate is paid, if CPT is not payable individually).

Claim denied because we are not PCP

- Contact carrier to confirm PCP was updated to CHW; if so, request retroactive date to accommodate claim. If not, contact patient and have them update the PCP to CHW and request retroactive date to accommodate visit date. Update visit and re-file appropriately. If unable to contact patient, make a note on EHR to have PCP updated prior to next visit.

Claim denied due to non-billable service or provider

- If a service and/or the provider is non billable, adjust visit.

Insurance Follow Up

1. CHW Billing Department is required to follow up on all monies owed to the Health Center by third-party payers in a timely and effective manner.
2. Insurance follow-up work is divided among CHW staff members equitably, based on the amount of work; according to the volume of accounts; work required by each payer as determined by the availability of automation, ease of communication, clarity of payment policies; and other factors that may dictate the time required to work the account.
3. CHW staff assigned the duty of insurance follow up are responsible for using all available resources and making all appropriate efforts to obtain outstanding payment on claims.
4. CHW Billing management or designee generates and provides reports from the practice management system to support Health Center staff engaged in follow up.
5. All actions taken on an account are documented, including the nature of the action, the date and the individual taking the action.
6. It is the responsibility of CHW staff members engaged in follow up to track future work generated, such as reviewing an account 30 days after an appeal letter is sent. Every staff member involved

should use the practice management system's automated follow-up tickler system, if available, or an automated calendar reminder system on his or her desktop.

7. Insurance follow up is divided into two distinct, but related responsibilities: rejection or denial management and open or outstanding claims.

Claims Rejections

1. CHW Billing staff is required to identify, monitor, and act on all submitted claims that are rejected by third-party payers.
2. CHW staff is assigned responsibility for reviewing and acting on all rejected or denied claims.
3. These staff members receive all correspondence regarding rejections within one business day of receipt at the CHW (during the payment posting process).
4. All rejections are reviewed and acted upon within 2-3 business days of receipt.
5. CHW staff use all available resources to research and correct the claim, including but not limited to documentation of the service, medical literature, precertification and authorizations, procedure and diagnosis coding manuals and reference materials, specialty society policy statements, third-party payers' payment policies, and state and federal government coverage policies.
6. Depending on the nature of the rejection, a claim is corrected and resubmitted, or an appeal is communicated over the telephone, via the payer's website or in writing to the third-party payer.
7. Rejected claims are not resubmitted without documentation of the service. Identifying claims without documentation of the service must be brought to the attention of the CHW compliance officer immediately.
8. Rejected claims are not resubmitted without corrections. Resubmitting a rejected claim without correcting it is grounds for disciplinary action.
9. The business office monitors, and research claims denied by third-party payers to determine the causes of rejections. The claims rejection report, generated from a manual tracking report by CHW staff or automatically from the practice management system, is analyzed to determine specific claims that have been denied and the causes for denial. The analysis is used to train providers and staff.
10. CHW staff will work to proactively identify and resolve any problems with open or outstanding claims from third-party payers.
11. A CHW staff member assigned responsibility for insurance follow up runs an open claims report once a month, at minimum.
12. A report is run that identifies all outstanding claims, by payer and based on the payer's average payment timeframe. For example, if CHW expects all clean Medicare claims to adjudicate properly within 14 days, an open claims report is run for all outstanding claims more than 15 days. The report is organized in hierarchical order, with the highest dollar amount outstanding listed first.

13. The staff member responsible for this function uses all of his or her skills, experience, resources and knowledge to identify the status of an outstanding claim and take action. Action may include, but is not limited to:
    a. Identifying that the claim was never received and resubmitting the claim;
    b. Submitting medical documentation to third-party payers if the claim is under review;
    c. Appealing an adverse decision for payment; or
    d. Communicating with the patient if the third-party payer is waiting for information from the patient.
14. If the staff member identifies a series of open claims from a specific date-of-claim transmission, the billing management or designee is alerted to determine if the source of the open claims was a failed batch (i.e., it failed to transmit to third-party payers). In that case, the affected claims are resubmitted immediately.
15. The staff member is expected to follow up on all outstanding claims until payment is received or a determination is made that the claim should be transferred to another party's responsibility or written off.

Write Offs

1. CHW billing staff will track and monitor all monies that are written off from the original charge submitted to a third-party payer. Two distinct categories of write offs are handled and monitored separately: contractual amounts, which are considered uncollectible because of a contractual agreement with a third-party payer and non-contractual amounts, which are considered uncollectible for reasons other than the contract. See Adjustments for Sliding Fee Policy
2. To track and monitor all write offs, CHW maintains a dictionary of detailed adjustment codes for contractual and noncontractual write offs. The noncontractual write offs also may be attached with transaction message codes, if applicable.
3. Billing office staff may write off contractual adjustment amounts when payments are posted to the practice management system. These write offs must be done using appropriate contractual adjustment codes.
4. From time to time, CHW staff may work on an account that has an outstanding balance with a health plan that cannot be collected. The reasons for CHW's inability to collect on the account may include, but are not limited to, a missed timely filing or appeal deadline, or failure to obtain an appropriate authorization or referral. Billing management reviews adjustment batches daily for accurateness.

X. MEDICAL FEE WAIVING POLICY & PROCEDURES

Related Form:

Related Policy: Refusal to Pay Policy; Sliding Fee Program Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

In accordance with the mission of Coastal Health & Wellness (CHW) and as an FQHC, it is our fundamental policy that the lack of means does not hinder care while additional ensuring that each of our patients are treated equally and fairly.

Procedures

1) Patients who present for care without the means for payment should follow first the policy for Sliding Fee Program to determine their poverty level. The patient who falls into a category that they are unable to fulfill must further discuss with the eligibility specialist on their current financial hardship (e.g. bankrupt, loss of employment, loss head of household) and/or medical hardship (e.g. terminally ill) to provide protection from undue financial burden. The fees may be reduced or waived all together.
2) It is CHW's Policy to identify specific circumstances for patients when CHW will waive or reduce fees or payments required by the center due to any patient's inability to pay. CHW's waiver process is as follows:
3) All attempts are made by billing and front desk to collect the payment in full. In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by eligibility, billing or designated staff. Any waiving of charges should be documented in the patient's file along with an explanation.
4) Patients that are screened and identify as homeless may fall into a category also known as CHW Care. Patients approved under CHW Care are allotted under a $0 fee for "immediate medical needs". All other services that don't fall under this criterion, will be charged under a category I.
5) Other waiver criteria include but is not limited to the following:
    a) Chronic illness
    b) Financial problems related to transportation or other unexpected expenses
    c) Natural disasters
        i) House fire
        ii) Loss of primary income sources
        iii) Death of a family member defined above

d) The site lead and above may make an exception in the fees once the financial hardship is established. Documentation of the required fee, the amount of fee to be waived and the specific reason and length of hardship must be documented in the patient record. All documentation must be completed, and the additional hardship will be in effect for a period of up to 3 months and then re-evaluated.

e) It is the responsibility of front office department to follow guidelines to prevent and detect the occurrence of fraud and abuse of medical fee waiving.

f) In the case of patient deceases and a copy of death certificate is provided, the outstanding balance on deceased patient account shall be waived or written off by billing department.

g) The decision to waive fees will be applied and made available consistently to all qualified patients

XI. REFUSAL TO PAY POLICY & PROCEDURES

Related Form: Registration Form; Payment Plan Form

Related Policy: Medical Fee Waiving Policy; Sliding Fee Program Policy

Responsible Department: Billing Department; Eligibility Department; Front Desk Department

Board Approval Date:

Policy

1) In accordance with the mission of Coastal Health & Wellness (CHW) and as an FQHC, it is our fundamental policy that the lack of means does not hinder care while additional ensuring that each of our patients are treated equally and fairly. This policy provides guidance for identifying and handing refusal or unwillingness to pay.
2) CHW distinguishes the difference between refusal to pay and inability to pay and notifies patients that refuse to pay of:
    a) Amounts owed and the time recommended to make such payments.
    b) That they will receive statements for their services.
    c) That CHW offers other assistance such as meeting with a financial counselor, establishing payment plans, and looking for additional programs that may assist the patient.
    d) That some optional services, such as special dental services, contact lenses, referred out services, or supplies will not be given for patients that completely refusal to pay or comply with Sliding Scale policies.
3) A patient is deemed unwilling to pay if they:
    a) Declare they will not pay for anything at the time of service.
    b) Have a balance due more than $200 and have not made a payment within the last 3 months.
    c) Refuse or fail to make a payment as agreed in the formal payment plan after a payment plan has been signed.
    d) Refuse to meet with an eligibility specialist to have their financial status re-evaluated.

Procedures

1) Patients who express an unwillingness or refuse to pay will be referred to a billing / eligibility specialist to assess their current financial / medical hardship status as per CHW's policy. CHW provides several options to patients to pay and those options include payment plans, waiver policies, and financial counseling. CHW does not choose to limit or deny services if accounts are unpaid.
2) All patients who present for care without the means for payment should follow first the policy for sliding fee program to determine their poverty level; specifically filling out the sliding fee discount program registration form and income documentation (refer to *Sliding Fee Adjustment Code Policy &*

Procedures). A patient who falls into a category that they are unable to fulfill must further discuss with the billing/ eligibility specialist on their current financial hardship (refer to Medical Fee Waiving Policy).

3) If a patient verbally expresses an unwillingness to pay, they will be made aware of the option to apply for the sliding fee discount program and/or they will be informed option to set up a payment plan for amounts owed to CHW.

4) If a patient leaves the premises without paying for services, applying for the sliding fee discount program or establishing a payment plan, a billing alert shall be documented by the front office personnel. The patient will then be notified regarding their financial responsibility either via phone call and/or mailing statement.

5) If the patient does not try to pay or fail to respond within 60 days, this constitutes refusal to pay.

6) If the patient who has been deemed unwilling to pay presents with an acute medical problem that requires immediate attention, the patient will receive care as scheduling allows without regard to ability to pay. The patient will be informed of the current balance owed to CHW and made aware of the expectation for future payment.

XII. SLIDING FEE ADJUSTMENT CODE POLICY & PROCEDURES

Related Form:

Related Policy: Sliding Fee Program Policy, Billing and Collections Policies

Responsible Department: Billing Department

Board Approval Date:

Policy

In accordance with the mission of Coastal Health & Wellness (CHW) as an FQHC, it is our fundamental policy that no one will be denied care for their inability to pay. Therefore, if a patient is qualified for sliding fee program, a sliding fee adjustment (SFA) code will be applied as a write off code.

This policy is to set forth procedures that assure the SFA code is applied to only those transactions that are subject to sliding fee discount program.

All self-pay patients will have their fee identified (Category A thru Category E). The difference between the full price and the fee/payment received will be written off using Sliding Fee Adjustment (SFA) code. On a monthly basis, the billing coordinator will review charts with SFA code applied to the patient chart.

Procedures

Note that SFA code only applies to office visit CPT code (992xx and 993xx). Therefore, the sliding fee adjustment amount would be office visit price – patient payment for office visit. From the sample above, the sliding fee adjustment would be $345 - $35 = $310.

1) On a monthly basis, the Billing Representative will review sliding scale list of patients with balances greater than 180 days.
2) Adjustments shall be made according to agreed upon sliding fee percentage.

XIII. GOOD FAITH ESTIMATES

Related Form:

Related Policy: Sliding Fee Program Policy, Billing and Collections Policies

Responsible Department: Billing Department

Board Approval Date:

Policy

Patients have the right to receive a "Good Faith Estimate" (GFE) explaining how much your medical care will cost.

Under the law, health care providers need to provide patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

Our patients have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, etc.

Make sure patients are aware and you give them you a Good Faith Estimate in writing at least 1 business day before their medical service or item. Patients can also ask their health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

Patients receiving a bill that is at least $400 more than your Good Faith Estimate, can dispute the bill. The Billing Manager is responsible for researching any patient concerns regarding a GFE. The clinical leaders will respond to a patient's concern withing 5 business days of receipt.

A copy or picture of your Good Faith Estimate shall be saved in the patient's record. For questions or more information about Good Faith Estimates, visit www.cms.gov/nosurprises or contact our Billing and Collection Specialist at (409) 938-2248 or email@gchd.org.

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