POLICY AND PROCEDURES

SLIDING FEE SCALE/BILLING AND COLLECTIONS

It is the policy of Bullhook Community Health Center, Inc. to accurately invoice all patients and third party payers, and to keep accurate and timely accounts receivable records. It is the policy of Bullhook Community Health Center to charge only for services which are medically necessary. Evaluation and Management (E & M) coding will be completed in compliance with the current editions of American Medical Association’s approved references for “Comprehensive Guide to Current Procedural Terminology” (CPT) and “Dental Terminology” (CDT).

A. Patient Fee Schedule

1. The Chief Executive Officer (CEO), Chief Medical Officer (CMO), Chief Dental Officer (CDO), Patient Accounts Manager (PAM) and the Chief Financial Officer (CFO) will annually review and, if necessary, adjust the Bullhook Community Health Center’s patient fee schedule by June 30th of each year.
2. Adjustments to the patient fee schedule, as well as the establishment of charges for new and/or additional services, will take into consideration the cost of services, prevailing insurance allowable rates and patient fees charged in the service area.
3. The CEO will recommend for the Board of Directors approval, adjustments to the patient fee schedule as well as the establishment of charges for new and/or additional services.

B. Discount Schedule

1. Patients with household income above the federal poverty level, but less than two hundred percent (200%), shall be charged in accordance with an established sliding fee schedule.
   a. Documentation and verification requirements include: POI to determine patient eligibility.
   b. Patients are notified of SFS through signage, check in and check out.
2. Patient eligibility Family size and household income will include only the mother, father and dependent children under 18.\(^1\) Other adults in the household, even though related, are considered separately. Possible inclusion of others in the household income computation will be administered on a case by case basis by the PAM with approval by the management team.
3. The structure of the sliding fee scale the patient sliding fee schedule shall progress with arithmetic (straight line) increments from a nominal charge to patients at or below one hundred percent (100%) of the federal poverty level to full charges for people at or above two hundred percent (200%) of the federal poverty level.
4. Patients who qualify for a zero percent (0%) payment on the sliding fee scale will be charged for office visits at a nominal fee rate. Each of Bullhook’s principle service units (Medical, Dental,

\(^1\) “Discounted/Sliding Fee Schedule Information Package”, NHSC, HRSA, HHS, Revised February 2012.
Mental Health and Addition Counseling) will determine nominal fee rates in line with the uniqueness of services provided and approved by the Board of Directors.

a. Lab fees and DME may have separate nominal fees and sliding fee scales. Health center services, laboratory services and/or medically related supplies and equipment may be combined into a single fee, consistent with both prevailing standards of care and locally prevailing charges.

5. Patients with incomes greater than two hundred percent (200%) of federal poverty level will be charged the full amount for each service rendered.

6. Provisions for waiving fees and nominal charges Following an assessment and recommendation by the PAM, cases where services rendered to a SFS patient are determined to be too great of a financial hardship to the patient, charges may be adjusted by the CFO and signed by CEO to a level commensurate with the patient’s ability to pay on a case by case basis. Such circumstances include, but are not limited to:
   a. Extreme hardship cases with medical conditions requiring frequent or expensive care.
   b. Patients who have been determined to fall within one category on the sliding fee scale and later proved documentation justifying a new position on the fee scale.
   c. Patients who are temporarily limited in their ability to pay for the services rendered.

7. Patients who qualify for the sliding fee scale are eligible for one year from the date of qualification. At that time the patient will present current financial information in order to maintain qualification for the sliding fee scale.

8. Patients who do not qualify for SFS may have adjustments in extreme hardship conditions if there is a funding source other than the 330 grant to pay for the discount.

C. Payment at Time of Service

1. When services are rendered, self-pay patients shall be urged to make payments for such services, as well as make payments on any outstanding balance. Patients will be asked to pay their expected co-pays prior to being seen by the provider. A credit or deferred payment plan should be extended to patients.

2. An explanation of the collection policy will be given to all patients upon check-in.

3. Refusal to pay/unwillingness to pay

D. Fee Disputes

1. Patient statements (Patient balances only) will be mailed on a twenty eight day (28) invoicing cycle.

2. If a patient disputes the accuracy of his/her invoice, an attempt shall be made to resolve the disputed balance by telephone or in person with the PAM who will access the complaint and work with the CFO to come up with a satisfactory resolution. If this does not settle the patient’s dispute, the patient will be encouraged to utilize the patient grievance process.

E. Mail Receipts

1. Employees who receive payments in the mail will stamp a receipt date on all checks or money orders after all mail is opened. A tabulation will then be recorded for checks received and copies
made of received checks and receipts for credit card payments for posting to the PMS per procedure.
2. There will be no holding of cash receipts allowed.

F. Monthly Chart audits
   1. Monthly chart audits will take place by PAM or designee.

G. Data will be review annually SF DS and financial barriers to care

H. Follow-Up Regarding Patient Accounts
   1. Follow-up on Patient Accounts
      a. If the patient has an account that is past due the patient will receive two more monthly statements while there is still a balance due before entering their internal collection phase.
      b. After 90 days, if the patient makes no attempt to rectify the account, a collections letter will be sent and after 15 more days of no activity billing personnel will mark the account be reviewed.
      c. After 120 days of non-compliance the PAM will review the recommended accounts for collections and forward the list with PAM recommendations to the CFO.
      d. The CFO will review and release those that are to be turned over to collections. If a patient seeks to rectify their account with the PAM and satisfactorily meets policy requirements, the patient’s account may be pulled back from collections.
      e. The Finance Team (CEO, CFO, PAM) will meet monthly to review non-compliant patient accounts. The Finance Team may take into account the history of patient payments and the earnest efforts of the patient/guarantor or extenuating circumstances and adjustments will be given as deemed appropriate on a case by case basis only. All non-insurance adjustments are to be approved by CFO and documented.

I. Reconciliation of the Accounts Receivable Sub-ledger
   1. Accounts receivables deposits are entered on the daily deposit ledger and reconciled with Electronic Medical Record and general ledger at the end of the month.
   2. AR aging will be reviewed monthly for refund or collection determination.

____________________________________________________________________________ DATE______________
CHIEF EXECUTIVE OFFICER

____________________________________________________________________________ DATE ______________
CHIEF FINANCIAL OFFICER

____________________________________________________________________________ DATE ______________
CHAIR, BOARD OF DIRECTORS

Date first adopted 01/2008
Date revised/QI 12/2012, 10/2014
New date adopted/Board 11/10/2014
Next review date 11/10/2015