Sullivan County Department of Public Health

Title: Fiscal: Billing, Free Care and Bad Debts **Number**: AG-22 **Page Number:** 1 of 2	Original Approval: 2/04 Reviewed/ revised: 8/10, 6/11, 11/15, 5/24

Statement/ Purpose:
To provide uniform methods for applying rates, collections and bad debt processes. To provide quality patient care to all individuals who qualify for Public Health services without regard to patient's ability to pay or source of payment.

Authority:
Public Health Law 760.5(h)(4), 763.11 (11), 763.5 (f) of Title 10NYCRR

Application:
All CHHA clinicians, CHHA billing staff

Terminology:

Responsible Party:
Director of Patient Services

Cross-Reference:

General Information
Medicare & Medicaid Billing:
1. Notice of Admission (NOA) are submitted to Medicare within five days after the first day of the Start of Care visit.
2. Final bills are submitted at the end of the 30-day episode for each patient.
3. Medicaid Pediatric bills are submitted monthly.
4. New York Episodic Medicaid is submitted at the end of the 60-day episode for each patient.

In compliance with regulations, signed orders must be on file within thirty (30) days of the patient's admission date. No bill is to be submitted to Medicare or Medicaid unless a signed physician's order is on file for each patient for the service period being billed. Billing is to continue to follow-up with the agency Intake Office and Supervising Nurse in charge of Intake until signed physicians' orders are received.

Charity (Free) Care:
1. A patient is eligible for charity care if ALL the following conditions are met:
    a. The patient is unable to pay full charges and; is not eligible for covered benefits under Title XVII (Medicare) or XIX (Medicaid) of the Social Security act and;
    b. It is not covered by any for of private insurance and;
    c. Whose household income is less than 200% of the Federal Poverty Guidelines.

Note: Charity Care is reflected on the Agency's sliding scale based upon the most current Federal Poverty levels. The New York State Bureau of Home Care has interpreted the Charity Care guidelines in regard to third party insurance: It is permissible to include as Charity Care, the difference between the amount billed to an insurance company and the amount received and/or if a patient's third-party insurance does not cover a particular service. The service can be considered free care if the client otherwise meets the free care guidelines.

In the event that a patient refuses to provide household income information for the Application for Reduced Fees, the SPHN and/or the Director of Patient Services will be notified and a decision may be made to either not provide services or a negotiated rate may be considered.

Procedure:

1. Cost of services will be determined at regular intervals by a cost study. A full fee or sliding scale will be established on the basis of these costs. There is a minimum charge per visit on the sliding fee scale basis for Skilled Nursing, Therapies, and Medical Social Worker. A separate sliding scale fee chart is prepared for Home Health Aid services; for these services, there is a minimum charge per hour.
2. A Home Health Admission Consent is completed by the SCDPH clinician during the initial visit and is used to determine the fees and payment source. The Home Health Admission Consent must be signed permitting authorization to release information and permitting the Agency to bill third-party payers, when available. All third-party resources (Medicare, Medicaid, and insurance companies) will be billed and exhausted prior to billing the patient.
3. It should be noted that this applies to third-party insurances; it does not apply to Medicare and Medicaid. When third-party payers cover part of the cost, the patient will be billed the deductible or coinsurance portion as follows:
    a. If the insurance payment exceeds the sliding scale fee for that patient, the insurance payment will be accepted as full payment. If the patient has a sliding scale fee in excess of the insurance payment, the difference will be billed to the patient.
    b. Deductibles will be translated into visits and billed to the patient at their sliding scale fee. For example, if the deductible is $200.00 and the Agency per visit charge is $125.00, the patient would be billed for 1.6 (200/125) of their sliding scale fee.
    c. Co-payments will be billed to the patient on a per visit basis, not to exceed the amount of the patient's sliding scale fee per visit.
    d. All non-covered or disallowed visits will be billed to the patient at their sliding scale fee.

** It is important to note that there are no agreed upon rates for Medicare and Medicaid. Public Health Services accepts Medicare and Medicaid payments as full satisfaction of the amounts billed for covered patients. Medicare (under the Prospective Payment System) pays home health agencies for services rendered during the patients' 60-day episodes. Payment is based on the covered patients' diagnoses, ability to ambulate and toilet, extent of wound care needed, the extent of therapy services needed, etc. Effective 5/1/12, NY Episodic Medicaid became effective 5/1/12 for patients over eighteen (18) years of age; this pays home health agencies per each covered patient's 60-day episode++. Medicaid rates are paid per visit for home health agency services rendered to patients eighteen (18) years of age & younger; these rates are set annually by NYS Department of Health and are based on the statewide cost report results for the most recent cost report year.

++It's important to note that as part of the efforts of the Medicaid Redesign Team (MRT) and to comply with constraints of the NY Medicaid budget, provisions were made to change the structure of the NY Medicaid reimbursement for the Certified Home Health Agencies (CHHAs). During the one year period of April 1, 2011 to April 30, 2012, Certified Home Health Agencies will be reimbursed with a provider specific aggregate annual spending limit imposed. Following the end of that period, the new Episodic Reimbursement model was implemented.

4. Private Pay: Patients and families receiving services not covered by third party payers should meet the costs of service to the extent that their resources permit.
    a. Patients/ families who can afford to pay full fee are expected to do so. If the patient/ family does not wish to divulge financial information, full fee will be billed. (Note: oral reporting of income may be substituted for income information recorded on the Home Health Admission Consent upon the approval of an Agency Director).
    b. When a patient/ family is unable to pay full fee, a fee adjustment will be made. A fee adjustment is a reduction in the fee based on the patient's household income. Income of the patient/ family will be considered as their present income out of which they meet the costs of day-to-day living, whether the source is salary, Social Security, pensions, dividends, interest or other sources. Other resources, such as savings, property, and investments, will not be investigated or taken into consideration in determining the extent to which income is able to meet costs of service.
5. The patient should be assured that all information will be treated as confidential and that the determined fee will be adjusted if their finances change and merit adjustment.
    a. The CHHA clinician should give all information to the billing staff, who will be the patient using the Sliding Scale Fee Chart obtained from the Fiscal Administrative Officer/ Designee. If the income is less than the first column of the sliding fee scale and the patient is unable to pay anything, the patient may be designated for Charity Care status. (Note: The Sliding Scale Fee Chart is updated annually when the current year's federal poverty levels are published and in the Medicaid Eligibility section of the Center for Medicare and Medicaid Services website).
6. If the patient dies, and it becomes known that the estate might have the resources to meet the cost of the services rendered, the estate will be billed for any unpaid balance.
7. Government regulations require that patients and other payors be invoiced full fee; however, the fee adjustment will also be shown on the invoice, leaving a net amount due to the agency.
8. For cases where a lawsuit is pending for injuries for which the agency is treating the patient, partial payment should not be accepted unless there is a signed statement in the record that indicates:
    a. The patient and their family realize they are paying part fee, and
    b. The patient and their family agree to full fee upon settlement of the suit.
        i. It is preferable, in these cases to bill the client full fee, insuring that the lawyer handling the suit is aware of the full fee services.

Checks Returned for Insufficient Funds:

1. As mandated by Legislative Resolution #293-11 (adopted by the County Legislature on 6/16/11), the fee for each check returned for insufficient funds has been increased from $15.00 to $20.00.
2. If a patient's check is returned for insufficient funds, they will be responsible to pay the NSF check fee of $20.00 per returned check. The Senior Account Clerk or designee will information the Fiscal Administrative Officer (FAO) of the NSF check and give a copy of the returned check advice and the address of the patient. (Note: The returned check advice contains the check number, amount of the check and payor's name. If the payor is someone other than the patient, then the patient's name must be given to the FAO.
3. The FAO or designee will send a letter to the patient informing them of the following:
    a. The check number, check date and amount of the check which was returned for insufficient funds.
    b. The new amount due, consisting of the amount owed for services rendered plus the $20.00 NSF fee.
    c. His/ her personal check will no longer be accepted as payment. All payments must now be made in cash, money order or certified cashier's check.
4. A revised bill for services including the NSF check fee will be prepared by the billing office and enclosed with the FAO's letter.

Determining and Declaring Bad Debts:

The collection effort will be documented in the patient's electronic health record by copies of bills, follow-up letters, reports of phone calls, and personal contacts.

1. The billing staff will send out a second bill 60 days after the original bill was mailed along with a collection letter.
2. If there is no response from the second billing, the billing staff will send out a third bill 60 days after the second bill was mailed along with a second collection letter.
3. If no response is received from the third billing, the patient's name is put on a list of unpaid bills to be reviewed by Fiscal Administrative Officer/ Designee.
4. The list is reviewed with the Fiscal Administrative Officer at which time it is determined to write off the outstanding balance.
    a. Any outstanding bills over $500.00 will be considered for litigation and sent to the County Attorney. When patients or families refuse to pay and it is determined that they are capable of making payment, service may be terminated after a reasonable time has been provided for the client to make other arrangements for essential service. However, if the recipient of care cannot control payment and would suffer for lack of service, service will not be terminated, but every effort will be made to collect on the unpaid balance as noted above.