PATIENT REVENUE AND BILLING (800.23)

Payment Policy

Purpose: The purpose of this policy is to ensure that full payment for services is received prior to services rendered to clients. This is to help reduce the risk of loss revenue and keep services at a low and competitive price for clients in need of affordable quality health service.

Medical

1. Front desk personnel will inform patients of the amount due prior to their medical visit. Clients will be charged the highest CPT code. The cost of each procedure is based on the client's income level.
2. Client will pay the cashier (Front Desk Staff) If the cost of the office visit is lower than what was collected, the lower cost will be collected by the Front Desk personnel.
3 Medical Assistants will inform clients on the cost of labs ordered by the provider and the client will pay prior to the collection of the sample.

Payment

- Acceptable forms of payment are: cash, and personal checks.
- Returned personal checks that are unable to be billed will be noted in the client's records in the chart and Practice Management System. These clients can only pay by cash from this point forward. No exceptions.
- Returned personal checks will result in a $25 penalty fee to clients along with the amount owed.
- Payment plans will be negotiated by Front Desk Supervisor.

Billing Policy Statement

Policy Statement: KCCC provides access to services without regard for a person's ability to pay. However, given the limited availability of KCCC's, KCCC recognizes the importance of maximization of revenue from all sources. Thus KCCC's Billing, Credit and Collection Policy focuses on the revenue maximization and therefore, have the following emphases:

1. An adequate and competitive fee schedule and a corresponding schedule of discounts;
2. Prompt and accurate billing of third party payers;
3. Billing of patients in accordance with the schedule of discounts, and timely follow-up on all uncollected amounts;
4. Participation in insurance programs used by the KCCC patients,
5 Participate in favorable reimbursement programs; and
6. Bill according to the existing rules and regulations

KCCC also performs billing of patients without insurance, collection of co-payments and minimum fees, and screening for financial status in a culturally appropriate manner to assure that these important administrative steps do not, by themselves, present a barrier to care. KCCC 's billing procedures strive to avoid conflict with the KCCC's mission and mandate of Section 330 Program, while at the same time assure that the federal grant resources available to KCCC are used to address true financial access barriers to the maximum degree possible.

The KCCC's Billing, Credit and Collections Policy and Procedures specifically address the following components and discuss the procedures of how and/or when they are done.

1. A fee schedule for all billable services covering both reimbursable costs and non-covered costs comparable to prevailing local rates,
2. Method of discounting or adjusting fees based upon the patient's income and family size from current Federal Poverty Guidelines;
3. A system of billing patients and third-party payers within a reasonable period of time after services are provided, typically within 30 days,
4. Target for days in receivables for collections on billable services by payers;
5. Way to monitor collection rates on outstanding balances and follow-up or write-off such balances as appropriate;
6. Utilization of electronic systems for billing and insurance verification;
7. For prepaid plans, a system to receive timely notification of enrolled members, and to tie receipts of capitation payments to enrolled members regardless of utilization of services;
8. Expanded fee schedules to reflect the costs associated with non-billable services provided to patients;

Accountability

Billing Unit will implement the policy and procedures.

Procedure Guidelines

Below are the policy and procedures specific to each of the above (1) to (8).

1) A fee schedule for all billable services covering both reimbursable costs and non-covered costs comparable to prevailing local rates:

- Review of fee schedule of all CPT codes shall be done annually based on relative value units and other costs including translation and reimbursement rates of various payer sources.
- The fee schedule shall be forwarded to Management for final approval.
- Immediately after approval, the new fees shall be entered in PM System and notify clinic operations for the changes.
- Effective date of new fee schedule shall be announced to all billing and clinic operation staff.

2) Method of discounting or adjusting fees based upon the patient's income and family size from current Federal Poverty Guidelines (Sliding Fee Scale Table):

- Sliding fee scale table shall be developed annually every April 1 each year based on current Federal Poverty Guidelines.
- Separate discount shall be granted to patients under Family Planning as required by Title X.
- Update sliding fee scale table is submitted to the Board of Directors for approval annually.

3). A system of billing patients and third-party payers within a reasonable period of time after services are provided, typically within 30 days.

Patient Billing

- All patient statements by group are mailed monthly
- Second copies of statements shall be kept in billing office for unpaid claims follow up.
- Past Due notice statements shall be sent periodically

Third-Party Payer Billing

- All electronic claims shall be sent weekly regardless of volume

4) Target for days in receivables for collections on billable services by payers:

Patients
- Payments shall be required by the end of visits
- If patients are to pay at the later time, payments shall be done as soon as statements are received or by the next visit

Third-Party Payers
- Collections are expected to be received within 30 days from the date of service

5) Way to monitor collection rates on outstanding balances and follow-up or write-off such balances as appropriate:

- Aging report of all payers shall be generated monthly.
- Accounts that are over 45 days shall be investigated and if feasible, followed up by telephone calls.
- Denials shall be investigated immediately upon receipt of Remittance Advices from payers for correction and re-billing.
- List of accounts that have been over 180ays shall be submitted to CFO to consider other collection alternatives and/or write-off accounts.
- Writing-off of accounts whether for contractual adjustment or others shall be done after approval by CFO.

6) Utilization of electronic systems for billing and insurance verification:

Financial Screeners and Billers shall utilize the following electronic systems for insurance verification and coverage:
The Internet.
- to verify eligibility for Medi-Cal, FPACT, MHLA and other private insurances such as Blue Cross
- to activate/inquire/update FPACT eligible patients and deactivate the patients who are no longer eligible
- to perform CHDP enrollment
- to perform Cancer Detection Program: Every Woman Counts enrollment and verify the covered dates
- Point of Service (POS) to verify eligibility for Medi-Cal and FPACT.
- to verify eligibility for Medi-Cal and FPACT
- to activate/inquire/update FPACT eligible patients and deactivate the patients who are no longer eligible
- Automated Telephone Systems to verify patient's insurance coverage and eligibility

7) For prepaid plans, a system to receive timely notification of enrolled members, and to tie receipts of capitation payments to enrolled members regardless of utilization of services:

- Capitation EOB and payments shall be received from Med Point Management monthly.

8) Expanded fee schedules to reflect the costs associated with non-billable services provided to patients:

- All CPT codes associated with the visits, including those that are not covered by insurance plans and those that are covered by grants such as TB, Tobacco, HIV and others shall be entered in Payment Management System using standard fee schedule
- These non-billable services shall be identified and recorded and reflected in financial statements as Uncompensated Care Visits.
- Other services such as lab tests for patients with Insurance shall be recorded in PM System using fee profile with zero charges.

Sliding Scale services shall be recorded in PM System using fee profile for each discounted fee to reflect the total costs, the adjustments and net charges.