

# **Health Center Program Site Visit Protocol: Billing and Collections**

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# BILLING AND COLLECTIONS

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**Primary Reviewer:** Fiscal Expert

**Secondary Reviewer:** Governance/Administrative Expert (as needed)

**Authority:** Section 330(k)(3)(E), (F), and (G) of the PHS Act; and 42 CFR 51c.303(e), (f), and (g) and 42 CFR 56.303(e), (f), and (g)

## Document Checklist for Health Center Staff

### Documents Provided Prior to Site Visit:

- Registration, Eligibility, Outreach and Enrollment Procedures
- Current Fee Schedule for each service area (medical, dental, behavioral health, etc.)
- Billing and Collections policies or procedures and systems including:
  - provision(s) to waive or reduce fees owed by patients;
  - third-party payor billing procedures and/or contracts;
  - “refusal to pay” policy (if applicable); and
  - procedures for notifying patients of additional costs for supplies and equipment related to, but not included in the service (if applicable)
- List of provider and program/site billing numbers for Medicare, Medicaid and CHIP or any other documentation of participation (e.g., individual provider NPIs)

### Documents Provided at the Start of the Site Visit:

- Current data on the following metrics: collection ratios, bad debt write off as a percentage of total billing, collections per visit, charges per visit, percentage of A/R less than 120 days, days in A/R (for context on billing and collections efforts)
- Collection rate by payor source (Medicaid, CHIP, Medicare, and, as applicable, other public and private insurance) gathered from billing records for the past 1-2 years
- Sample of billing and payment records for charges requested from patients. For the sample, randomly choose 5 records for patient visits from across at least 3 unique services (e.g., routine primary care, preventive dental, behavioral health, OB) for a total of at least 15 total records reviewed:
  - Ensure the sample includes patients that are eligible for the health center’s sliding fee discount program (i.e., incomes at or below 200 percent of the Federal Poverty Guidelines (FPG))
  - If applicable, include records for patients that are not eligible for the sliding fee discount program (i.e., incomes above 200 percent FPG)
- Sample of two to three billing records where patient fees were waived or reduced
- Documentation of methods for notifying patients of additional costs for supplies and equipment related to, but not included in the service (if applicable)
- Documentation of cases where the health center has applied its refusal-to-pay policy within the past 2 years (if applicable)

- Documentation related to Determination of Fee schedule based on health center costs and locally prevailing rates (e.g., operating costs for service delivery, relative value units (RVUs) or other relevant data sources, Medicare/Medicaid cost reports)
- Documentation of participation in other public or private program or health insurance plans (if applicable) (e.g., list or copy of third-party payor contracts including any managed care contracts)
- Contracts with outside organizations that conduct billing or collections on behalf of the health center (if applicable)

## Demonstrating Compliance

### Element a: Fee Schedule for In-Scope Services

The health center has a fee schedule for services that are within the HRSA-approved scope of project and are typically billed for in the local health care market.

#### Site Visit Team Methodology

- Review fee schedule(s).
- Compare the health center fee schedule to Form 5A required and additional services.
- Interview CFO/financial or billing staff.
- Review most recent data and documentation of analysis used for determining and setting fees.

#### Site Visit Findings

1. Does the fee schedule include fees for all in-scope services typically billed for in the local health care market?

**Note:** Services on Form 5A that are not billed for in the local health care market may be excluded from the health center's fee schedule (e.g., transportation, translation, other non-clinical services).

YES       NO

If No, an explanation is required:

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### Element b: Basis for Fee Schedule

The health center uses data on locally prevailing rates and actual health center costs to develop and update its fee schedule.

#### Site Visit Team Methodology

- Review fee schedule(s).
- Compare the health center fee schedule to Form 5A required and additional services.
- Interview CFO/financial or billing staff.

- Review most recent data and documentation of analysis used for determining and setting fees.

### Site Visit Findings

2. Did the health center use data on locally prevailing rates and actual health center costs to develop its current fee schedule(s)?  
 YES       NO

If No, an explanation is required:

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## Element c: Participation in Insurance Programs

The health center participates in Medicaid, CHIP, Medicare, and, as appropriate, other public or private assistance programs or health insurance.

### Site Visit Team Methodology

- Review list of provider and program/site billing numbers or any other documentation of participation in Medicare, Medicaid and CHIP.
- Review documentation (if applicable) of participation in other public or private program or health insurance plans.
- Interview CFO/financial or billing staff.

### Site Visit Findings

3. Does the health center have documentation of its participation in Medicaid, CHIP, and Medicare?  
 YES       NO

If No, an explanation is required:

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4. Does the health center participate in other public or private assistance programs or health insurance?  
 YES       NO

If No, an explanation is required, including the justification that the health center provided as to why it does not participate in any other programs or insurance plans:

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## Element d: Systems and Procedures

The health center has systems, which may include operating procedures, for billing and collections that address:

- Educating patients on insurance and related third-party coverage options available to them (if applicable);
- Billing Medicare, Medicaid, CHIP, and other public and private assistance programs or insurance in a timely manner, as applicable;<sup>80</sup> and
- Requesting applicable payments from patients, while ensuring that no patient is denied service based on inability to pay.

### Site Visit Team Methodology

- Interview staff involved in the billing and collections process as well as staff involved in educating patients on insurance options (e.g., front desk staff, billing office staff, outreach and enrollment staff).
- Review billing and collections systems including third-party payor billing procedures and/or contracts.
- Review contracts with outside organizations that conduct billing or collections on behalf of the health center (if applicable).
- Review eligibility, education and, if applicable, enrollment procedures (e.g., new patient registration and screening procedures).

### Site Visit Findings

5. Was the health center able to provide at least one example of how it educates patients on the availability of insurance coverage options?

YES       NO

If No, an explanation is required:

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6. Does the health center have systems in place for billing Medicare, Medicaid, CHIP and other public and private assistance programs or insurance?

YES       NO

If No, an explanation is required:

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7. Does the health center have a system(s) in place for collecting balances owed by patients?

YES       NO

If No, an explanation is required:

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<sup>80</sup> For information on Federal Tort Claims Act (FTCA) coverage in cases where health centers are using alternate billing arrangements in which the covered provider is billing directly for services provided to covered entity patients, please refer to the [FTCA Health Center Policy Manual](#), Section I: E. Coverage Under Alternate Billing Arrangements.

8. When requesting payment(s) from patients, do the health center's billing and collections systems/procedures ensure that no patient is denied service based on inability to pay?  
 YES       NO

If Yes OR No, an explanation is required, including describing the systems or procedures:

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## Element e: Procedures for Additional Billing or Payment Options

If a health center elects to offer additional billing options or payment methods (for example, payment plans, grace periods, prompt or cash payment incentives), the health center has operating procedures for implementing these options or methods and for ensuring they are accessible to all patients regardless of income level or sliding fee discount pay class.

### Site Visit Team Methodology

- Review billing and collections systems and any related procedures for additional billing options or payment methods (if applicable).

### Site Visit Findings

9. Does the health center offer additional billing options or payment methods (for example, payment plans, grace periods, prompt or cash payment incentives)?  
 YES       NO

If Yes, an explanation is required specifying what additional billing options or payment methods are offered by the health center:

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10. **If Yes:** Does the health center have operating procedures for implementing these options or methods?  
 YES       NO       NOT APPLICABLE

If No, an explanation is required:

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11. Does the health center ensure these options or methods are accessible to all patients regardless of income level or sliding fee discount pay class?  
 YES       NO       NOT APPLICABLE

If No, an explanation is required:

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## Element f: Timely and Accurate Third Party Billing

The health center has billing records that show claims are submitted in a timely and accurate manner to the third party payor sources with which it participates (Medicaid, CHIP, Medicare,

and other public and private insurance) in order to collect reimbursement for its costs in providing health services<sup>81</sup> consistent with the terms of such contracts and other arrangements.

### Site Visit Team Methodology

- Review collection rate by payor source (Medicaid, CHIP, Medicare, and, as applicable, other public and private insurance) gathered from billing records for the past 1-2 years.
- Review third-party payor billing procedures.
- Interview CFO and staff involved in the billing and collections process.

### Site Visit Findings

12. Do collection rates indicate that claims are submitted within 30 days of the service(s) provided?

- YES       NO

If No, an explanation is required:

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13. Was the health center able to document that it corrects and resubmits claims that have been rejected due to accuracy?

- YES       NO

If No, an explanation is required, including specifying any cases in which Medicare, Medicaid or any other third party payor has suspended payments to the health center and why:

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### Element g: Accurate Patient Billing

The health center has billing records or other forms of documentation that reflect that the health center:

- Charges patients in accordance with its fee schedule and the sliding fee discount schedule (if applicable);<sup>82</sup> and
- Makes reasonable efforts to collect such amounts owed from patients.

### Site Visit Team Methodology

- Review fee schedule and the appropriate corresponding sliding fee discount schedule, including sliding fee schedules that differ by service (if applicable) (e.g., Dental Sliding Fee Discount Schedule).
  - Review sample of billing and payment records for charges requested from patients.
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<sup>81</sup> This includes services that the health center provides directly (Form 5A, Column I) or provides through a formal written contract/agreement (Form 5A, Column II).

<sup>82</sup> See Health Center Program Compliance Manual, [Chapter 9: Sliding Fee Discount Program](#) for more information on the sliding fee discount schedule.



- Review billing and collections systems and any related procedures and interview staff involved in collections.

### Site Visit Findings

14. Are patients billed for services in accordance with the health center's fee schedule and are the correct discounts applied to these charges (if applicable)?
- YES       NO

If No, an explanation is required:

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15. Does the health center attempt to collect amounts owed for charges, co-pays, nominal charges, or discounted fees (e.g., health center sends statements for outstanding balances, makes phone calls)?
- YES       NO

If No, an explanation is required:

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### Element h: Policies or Procedures for Waiving or Reducing Fees

The health center has and utilizes board-approved policies and operating procedures that include the specific circumstances when the health center will waive or reduce fees or payments required by the center due to any patient's inability to pay.

### Site Visit Team Methodology

- Review policies and procedures that contain provision(s) to waive or reduce fees owed by patients.
- Review a sample of two to three billing records where patient fees were waived or reduced.

### Site Visit Findings

16. Does the health center have a provision(s) in policy and procedure that addresses circumstances or criteria related to a patient's inability to pay (regardless of patient income level) to ensure that fees or payments will be waived or reduced?
- YES       NO

If Yes OR No, an explanation is required, including specifying whether the health center waives or reduces fees or payments:

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17. Does the health center follow the provision(s) in its policies and procedures for waiving or reducing fees or payments?
- YES       NO       NOT APPLICABLE

If No, an explanation is required:

## Element i: Billing for Supplies or Equipment

If a health center provides supplies or equipment that are related to, but not included in, the service itself as part of prevailing standards of care<sup>83</sup> (for example, eyeglasses, prescription drugs, dentures) and charges patients for these items, the health center informs patients of such charges (“out-of-pocket costs”) prior to the time of service.<sup>84</sup>

### Site Visit Team Methodology

- Interview staff involved in billing.
- Review billing procedures and methods for notifying patients of additional costs for supplies and equipment related to but not included in the service (if applicable).

### Site Visit Findings

18. Does the health center provide and charge patients for supplies and equipment related to but not included in the service itself (e.g., eyeglasses, dentures)?

- YES       NO

19. **If Yes:** Does the health center have a method for notifying patients about “out of pocket” costs for such supplies and equipment, in advance of service provision?

- YES       NO       NOT APPLICABLE

If No, an explanation is required:

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## Element j: Refusal to Pay Policy

If a health center elects to limit or deny services based on a patient’s refusal to pay, the health center has a board-approved policy that distinguishes between refusal to pay and inability to pay and notifies patients of:

- Amounts owed and the time permitted to make such payments;
- Collection efforts that will be taken when these situations occur (for example, meeting with a financial counselor, establishing payment plans); and
- How services will be limited or denied when it is determined that the patient has refused to pay.

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<sup>83</sup> These items differ from supplies and equipment that are included in a service as part of prevailing standards of care and are reflected in the fee schedule (e.g., casting materials, bandages).

<sup>84</sup> For related information on revenue generated from such charges, please see Health Center Program Compliance Manual, [Chapter 15: Financial Management and Accounting Systems](#).

## Site Visit Team Methodology

- Interview staff responsible for billing and collections.
- Review billing and collection policies and procedures.
- Review of refusal-to-pay policy (if applicable).
- Review documentation of cases where the health center has applied its refusal-to-pay policy within the past 2 years (if applicable).

## Site Visit Findings

20. Does the health center limit or deny services to patients who refuse to pay?

- YES       NO

21. **If Yes:** Does the health center have a refusal to pay policy?

- YES       NO       NOT APPLICABLE

If No, an explanation is required:

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22. Does the health center:

- o Distinguish between refusal to pay and inability to pay?  
 YES       NO       NOT APPLICABLE
- o Notify patients of amounts owed and the time permitted to make such payments?  
 YES       NO       NOT APPLICABLE
- o Notify patients of collection efforts that will be taken when these situations occur (for example, meeting with a financial counselor, establishing payment plans)?  
 YES       NO       NOT APPLICABLE
- o Notify patients how services will be limited or denied when it is determined that the patient has refused to pay?  
 YES       NO       NOT APPLICABLE

If Yes OR No, an explanation is required, including specifying whether the health center has a policy or procedure that addresses these areas:

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23. In cases where the health center has limited or denied services to a patient(s) due to refusal to pay, was the determination consistent with health center policy or procedure?

- YES       NO       NOT APPLICABLE

If Yes OR No, an explanation is required, including how the determination was made:

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