Public Health – Seattle & King County
CHS & Prevention Divisions / Public Health Centers

General Fee Collection/Billing Guidelines

> ❖ **Services will <u>not</u> be denied to any client because of the client's inability to pay assessed fees.**

INSURANCE BILLING: Third party coverage plans (Medicaid, Take Charge, etc.) will be billed with certain restrictions on commercial insurance, see Public Health-Seattle King County Insurance Coverage Policy.

<u>Exceptions to insurance billing</u>:

- Travel Immunizations -no insurance will be billed
- Confidential services- clients requesting insurance correspondence not be sent to home
- Certain types of non-covered services, such as Sports Physicals (see Medicaid Waiver)

DISCOUNT FEE STRUCTURES: Public Health - Seattle & King County CHS division utilizes two discount fee structures: Tiered fixed fee (or Flat Fee) and Sliding Fee Scale. Discounts are based on the Federal Poverty Level (FPL) as determined by the client's household size and income (see "Family Size and Household Income Guidelines"). FPL is updated semi-annually, and is self-reported. PHSKC does not send out patient statements for self-pay clients; however past due patient balance collection efforts are attempted at every patient visit and no client is denied service due to inability to pay. Pharmacy fees are discounted to a flat rate per each prescription, as referenced in the PHSKC Pharmacy Fees Policies and Procedures.

<u>Exceptions to Discount Fee Structures:</u>

Partial discounts to Dental lab fees:

- Dental lab fees - Lab costs are covered by the patient prior to receiving the denture or partial. Clinic visit charges are not assessed concurrently (that is, lab fees override any other charges for that visit).

Discounts do not apply for the following situations:

- Clients receiving services and experiencing hardships will have all fees waived on a case by case basis, please refer to the PHSKC Fee Policy.
- Client is seen by a provider for a non-billable visit (no charge is assessed for non-billable service).
- Travel immunizations and PPD administrations (TB tests) - fees are based off the cost of the vaccine administered.

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1) Tiered Fixed Fee Structures (Flat Fees)

The discount fee structure utilized by the Primary Care, Family Planning (non-Title X), and Dental clinics consists of a tiered fixed fee amount. The flat fee specified charge is assessed in five tiers; discounts applied in four of the five tiers through 200% FPL as designated by Pay Tier categories "Flat Fee A" through "Flat Fee D" according to the following table:

Tiered Fixed Fee Structure: **Primary Care, Family Planning, & Dental Clinics**

Pay Tier	Flat Fee A	Flat Fee B	Flat Fee C	Flat Fee D	Full Fee E
FPL	"Nominal fee" 0-100%	101-125%	126-150%	151-200%	>201%
Primary Care/Non-Title X Family Planning	$15*	**$20**	**$30**	**$35**	No discount
Dental	$15*	**$25**	**$40**	**$45**	No discount

***NOMINAL FEE:** A nominal fee of $15 is assessed for Pay Scale Flat Fee "A" self-pay clients receiving Primary Care, Dental services, or STD Program services.

Exceptions to Nominal Fee: The following are exempt from minimum fee assessment:

- Clients experiencing a hardship will have this fee waived.
- Clients receiving Family Health services for STD or contraceptive care *when assigned as **primary diagnosis** for the visit.*

2) Sliding Fee Scale-Per Title X Federal Grant Program

The discount fee structure utilized by the Family Planning and STD clinics for Title X services consists of a percentage discount of total fees for services rendered. The discount percentage is offered through 250% FPL and is assessed by designated Pay Status categories "A" through "D" according to the following table:

SLIDING FEE SCALE: **Title X Family Planning Program Area**

Pay Status	% of FPL	Slide amount
A clients	0-100%	0% (or 100% discount)
B clients	101-150%	25% (or 75% discount)
C clients	151-200%	50% (or 50% discount)
D clients	201-250%	75% (or 25% discount)
E clients	251% or more	100% (no discount)

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DONATION REQUESTS: All clients who do not owe a fee should be asked for a donation to Public Health, including all insured clients (Medicaid, Take Charge, BHP without co-pay, etc.).

MEDICARE ABN: If a client with Medicare Type B coverage is receiving a service that Medicare *may* cover under certain circumstances but is not expected to be covered for the current visit, the client must sign a Medicare ABN ("Advance Beneficiary Notification of Non-coverage" CMS R-131) form.

- ABN is not required for Dental services or MSS/ICM and WIC services.

MEDICAID WAIVER: If a DSHS client is receiving a service that DSHS does not pay for, the client must sign a DSHS 13-879 form "Agreement to Pay for Healthcare Services" (formerly known as "Medical Assistance Waiver") prior to receiving the service. If form is not signed, services will revert to guarantor responsibility and any associated fees will be discounted based on the client's FPL.

Exceptions to Medicaid Waiver: A signed DSHS 13-879 form is ***not*** required for:

- TAKE CHARGE or Family Planning Only clients receiving services that are not within the scope of the client's benefit package.
- A DSHS-contracted Managed Care (MC) enrollee receiving nonemergency service(s) from providers outside of the MC network without authorization from the MC organization
- DSHS clients paying a spend-down.