LifeStream

ADMINISTRATION -- FISCAL/ACCOUNTING

OUTPATIENT FEE ASSESSMENT AND COLLECTIONS
OPERATIONAL PROCEDURE

March, 1988 (7/14, 4/17, 4/20, 3/21, 3/22, 3/23) **Policy Ref**: 110-06

Reviewed/Revised: December 2024 **Procedure**: 110-04

A. PURPOSE:

Fees for services are an essential part of financing the Center operations. Payment for service is both normal and enhances the therapeutic value of the service. Therefore, it is the function of this procedure to establish a mechanism wherein consumers pay some part of the cost of service received, to the extent of the consumer's ability to pay. No emergency services shall be denied because of a failure to pay the assigned fees or because of county or state of residence.

B. PROCEDURE:

I. Initial Contact

a. Staff scheduling an intake appointment for a potential consumer, either in person or over the telephone, shall inform the potential consumer of the Center's fee policy. This information shall include the Center's policy regarding fees and the opportunity to set fees for services. The potential consumer shall be asked to bring verification of income and any information regarding any third-party coverage for payment of fees (including insurance card) to their first appointment.

b. Minor consumers (under 18 years of age) or a consumer for whom a legal guardian has been appointed must be accompanied by a parent or guardian to execute forms normally required to be signed by a consumer, except:

1. Married consumers are not considered minors regardless of age.

2. The institutional representative will act as the guardian of consumer and estate for a minor child in a public or private institution. Parents presenting a minor child are responsible for all charges based on the parent's financial resources.

c. Consumers with a previous balance may be refused services. However, services shall not be denied before a clinical decision is made as to whether to deny services. The decision must be based upon the consumer's current mental condition and the need for treatment. No emergency services shall be denied because of a failure to pay the assigned fees.

d. All persons requesting services, regardless of referral sources, shall be required to pay for services based on the Center's sliding fee schedule and other contractual allowances. The fee schedule can be reduced

based upon extenuating circumstances as approved by a Program Director or a Vice President.

II. Admission, Fee Assessment and Adjustments

a. Consumer's demographic, case history and financial information shall be obtained at the intake/screening during the consumer's first scheduled Center appointment. Assistance from collaterals may be required to complete this information for consumers with severe mental or emotional problems.

b. Patient Guarantor and Agreement for Treatment shall be completed for each consumer during the initial session. Center policy is to charge each consumer for services based on their ability to pay.

1. Charges for services are set during the initial interview if this has not already been done via telephone contact. Each consumer is established a charge for services based on their ability to pay. The clerical staff shall set the fee using the Center's Sliding Fee Scale. The fee is based on gross income and the number of dependents in the household. These are the only criteria for eligibility for the sliding fee scale program. The Center will not discriminate based on age, gender, race, sexual orientation, creed, religion, disability, or national origin. The Federal Poverty Guidelines (FPG), are used in creating and annually updating the sliding fee scale (SFS) to determine discounts.

a. The most current published FPG will be used in the SFS and updated by appropriate fiscal department staff as soon as possible, not to lapse 7 days past release date.

b. The SFS are graduated to include a category Nominal Fee for consumers and families at or below 150% FPG, and graduated categories in the table below between 150% and 300% FPG, at no time will discounts be offered to patients above 300% of the FPG unless they are associated with other funding sources or exemptions.

% FPG	% Discount
0-150%	Nominal Fee
151-165%	96%
166-180%	94%
181-195%	89%

% FPG	% Discount
196-210%	81%
211-225%	70%
226-240%	56%
241-255%	39%

% FPG	% Discount
256-270%	19%
271-285%	10%
286-300%	5%
>300%	0%

c. Consumers at or below 150% FPG will be asked to pay a nominal charge per visit which is $3 for outpatient and $2 for residential. However, consumers will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment. This nominal fee does not reflect the

true cost of care and has been determined to be nominal from the consumer perspective and consistent with other behavioral health providers in the greater Central Florida region. The nominal fee will always be less than the first sliding fee pay class.

d. Gross income is defined from the guidance of IRS Form 1040 including W2 and 1099 wages, tips, unemployment compensation, social security and SSDI, retirement or pension income, alimony, rental or investment income, and capital gains income.
    i. NOT considered income: Child support, veteran's disability payments, SSI, worker's compensation, loan proceeds, food stamps or WIC payments.
e. Documents for Income Verification include, but are not limited to:
    i. Prior year's Federal Tax Return or W-2
    ii. Paycheck stubs, bank statements showing direct deposits, or written verification of wage from employer
    iii. Court documents or written attestation from a governmental agency
    iv. Self-Declaration
        1. Eligibility for Medicaid through presentation of a card or through download of an eligibility certificate from the Medicaid web portal justifies self-declaration of income of all household members.
f. Household size is determined using the IRS definition of tax filer, spouse, and taxable dependents. Taxable dependents do not include anyone over 18 years of age UNLESS they are financially dependent or disabled. Total annual income should include income from all sources for all household individuals.

2. Consumers residing in an adjoining county outside the Center's catchment area that do not have a third-party payment source shall be referred to the behavioral health center in their county for services. However, no consumer shall be denied access to emergency services based on the ability to pay or place of residence.
3. Consumers shall be informed that services are on a cash basis and payment is expected at the time services are rendered.
4. Those consumers refusing to participate in the fee assessment

process or electing to not assign insurance benefits shall be charged full fee for services. Such refusal shall be explained to the consumer and be documented by the clerical staff in the Center's Billing System within the Electronic Health Record (EHR).

5. A ten-dollar ($10.00) charge may be assessed for failed appointments and for individual, family, or marital sessions canceled or rescheduled without at least prior day notice to the attending clinician or a member of the clinic office management staff. Any such charge shall be issued directly to the consumer of record for payment, and continuation of outpatient services may depend on the consumer's payment of the assessed fee.
6. Assessments become effective on the date of intake and are evaluated every six (6) months thereafter.
    i. The clerical staff is to reassess at each six (6) month interval and evaluate the fee contract and prepare a reassessment when due. If the current assessment is to be continued as written, the clerical staff may note "No Change" in the Center's Billing System within EHR.
    ii. The clerical staff may reassess fees whenever deemed appropriate by changes in the consumer's financial status, or when the consumer is to receive services not included in the initial assessment.

III. Third Party Reimbursements

a. Private Insurance/PPO/HMO Contracts/Champus, et al

1. When a consumer with third party coverage first contacts the Center, the procedure listed below shall be followed.
    i. The clerical staff shall obtain insurance information and have the consumer sign the authorization on the Patient Guarantor form. If special forms are needed for filing insurance, the clerical staff must obtain them from the consumer.
    ii. The insurance card is to be copied and the copies are to be forwarded to the Insurance Department.
    iii. The clerical staff shall call for verification and authorization of services. They shall notify the provider of services as to how many services are authorized prior to the consumer receiving services. A copy of the completed authorization/verification form shall be filed in the consumer's chart and the original filed in the Insurance Department. In the event a prospective consumer requires immediate treatment, every attempt

will be made to obtain, authorize, and verify insurance information and coverage while the consumer is on site.

iv. If the consumer refuses to sign an Assignment of Benefits form, or if the insurance benefits will be paid to the consumer only, the fee shall be assessed at 100% for services covered by the consumer's assessment and treatment.

v. Every attempt shall be made to allow the consumer full benefit of their insurance coverage by assuring that the services they receive are delivered by the clinical category specified under their insurance policy. The Center reserves the right to recommend the service indicated to be in the best interest of the consumer and clinician.

vi. The steps below must be followed in processing the insurance claims for consumers:

a) Medical practitioner electronically signs: Initial Evaluation, Face Sheet, Treatment Plan (1 x only) and Psychiatric Evaluation.

b) Send Insurance Department a READABLE copy of: Face Sheet, front and back of insurance card (with phone number for verification), Consumer Guarantor Agreement, and income.

c) Document on Feedback when insurance confirmation is received. Indicate "FULL FEE INS" on Face Sheet in scale status box. Highlight chart label yellow.

d) Collect co-payment at the time of service. ANY OTHER ARRANGEMENT MUST BE APPROVED BY BUSINESS OFFICE.

a. Consumers who have insurance coverage and are eligible for the SFS will pay no more than if they had used the SFS discount alone. Fees will be processed and filed with primary insurance, secondary insurance, and tertiary insurance. After all payments from insurance, the remaining amount will be reduced to the eligible sliding fee schedule amount.

e) Diagnosis and scaled fee should be documented.

f) Notify Insurance Department of any changes in consumer's status such as change in income,

insurance, or diagnosis.

g) Unemployed, disabled, or retired consumers' Face Sheets should indicate an "unemployed teacher" or "disabled steel worker" or "retired postal worker."

h) When processing insurance for children whose parents both have coverage, the BIRTHDAY RULE must be applied. The parent whose birthday comes first would have primary coverage (i.e.: father's birthday is 5/01, mother's birthday is 5/27; the father's insurance would be primary).

i) Consumers who have an insurance which we have a PPO or HMO contract with shall only be billed for the amount agreed upon in the contract.

j) The Insurance Department shall file primary and secondary insurance. The consumer, however, shall be responsible for their bill.

b. Medicare and Medicaid

1. Consumers who present with Medicare or Medicaid will have their coverage verified prior to having services rendered. Questionnaire must be completed on all Medicare consumers. If it is found there is another insurance that is primary, that insurance shall be filed prior to Medicare or Medicaid.

2. Medicare and Medicaid programs cover only certain services. For those services not covered by the programs, the consumer shall be given an Advanced Beneficiary Notice advising them of the non-covered services before the service can be provided.

i. LifeStream Behavioral Center will bill Medicare and/or Medicaid for all medically necessary services up to maximum benefits.

NOTE: LifeStream will collect all co-pays and deductibles from Medicare and Medicaid consumers as required.

ii. During the scheduled reassessments, the clerical staff shall see each consumer with private insurance, CHAMPUS, Medicare and/or Medicaid to update information on third party coverage.

IV. Payment and Collections Process.

a. It shall be the responsibility of each clerical staff to obtain insurance information. This includes insurance forms, copies of Medicare and/or Medicaid cards, etc.

b. Each clerical staff shall be responsible for obtaining third party coverage information reassessment.

c. The clerical staff shall notify all consumers of the Sliding Fee Scale and offer each patient the application upon admission. Staff will also inform patients of additional costs for services.

    i. Notifications of the Sliding Fee Scale are posted in the clinic waiting areas, informing the patient how to apply.

    ii. The Application for Financial Assistance is also available on LifeStream's website

d. Payments are accepted by cash, check, or credit card at or before the time of service.

e. Consumers with the ability to pay the agreed charges for service but refusing to do so may be denied further services until an agreement on a payment schedule has been set. The consumer's mental condition and need for services must be considered when making a determination to deny services. Termination of further services shall be documented by the service provider in the EHR under the consumer's 'Next Appointment' section. The service provider shall document such actions in the consumer's clinical record and report this determination to the program manager or supervisor.

PROCEDURE APPROVED:

Patricia Mings
AVP of Risk and Corporate Compliance

12/18/2024
Date