

GENERAL ADMINISTRATION 7.0

Charges for Medical Services -- 7.9

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By: Cathy R. Taylor, DrPH, MSN, RN
Assistant Commissioner
Bureau of Health Services

POLICY

Charges for medical care services provided by county and regional health departments/clinics shall be in accordance with Tennessee Department of Health Rules and Regulations Governing Fees for Medical Care Services, Chapter 1200-17-2.

APPLICABILITY

This policy applies to all Local Health Departments and Regional Office Clinics.

PURPOSE

To insure consistent implementation of the Rules and Regulations Governing Fees for Medical Care Services.

PROCEDURE

The Fee Rules set out either the method of establishing the fee or the actual amount of the fee for services provided in county and regional health departments/clinics. Generally, fees are the amount established by the Medicaid Maximum Price list, other approved TennCare amounts or the Department's fees based on a Resource Based Relative Value Study (RBRVS).

The Bureau Office has the responsibility for coordinating changes in the approved fee schedules when the price lists change or when additional billable services are added to the fee schedule.

The fee rules specify the circumstances that exempt individuals from the personal obligation to pay fees. Also specified in the fee rules is the requirement that the family planning sliding fee scale be the uniform sliding scale for all services. *It is the responsibility of all directors of county and regional health departments/clinics to insure that a sign is posted in the reception area which states that services are available on a sliding fee scale basis.*

In order to become eligible for the sliding fee for SERVICES WITH A FEE, the patient must declare their income at the initial visit, and each six (6) months thereafter. Otherwise, the patient will be expected to pay 100% of the charges for the services provided. PROOF OF INCOME shall not be required except in clinics that are funded by federal grants requiring such (i.e. 330 RHI grantees).

Income information shall be recorded on the PTBMIS Financial Screen. The **Informed Consent/Signature Sheet, PH-1530**, must be signed by the patient. Whenever new income or family size documentation is declared or documented, that information shall be updated on the PTBMIS Financial Screen and the **Informed Consent (PH-1530)** signed.

Patients will be informed of the charges for services received before they leave the health department. Collection efforts will be made at the local health department for the current charges and any outstanding balance.

If a family planning patient is under the age of 21 or if the patient is a confidential (no contact) patient, a declaration of income will be acceptable in lieu of providing documented proof of income.

Eligibility for certain programs, such as WIC and presumptive eligibility, is determined by family income and family size. Proof of income documentation will be required for WIC program services. Presumptive eligibility will be obtained by patient declaration. See 2/29 memo from Mark spears

In the case of specific programs governed by rules and regulations setting forth defined eligibility periods, such as Children's Special Services, program rules shall prevail and approved program forms shall be used to document the information.

Family size shall be determined based upon the policy in place for TennCare presumptive eligibility, i.e. mother and unborn child count as two. In the case of specific programs governed by rules and regulations setting forth defined family size parameters, program rules shall prevail.

Since patients are usually sensitive about revealing their income, it is essential that income information be requested in a manner which will preserve the patient's dignity and privacy. Individuals who choose not to reveal income information shall be treated as having income in excess of 200 percent of the federal poverty level (full charge).

Patients must be informed that payment, or identification of payment source, is expected when services are delivered. No fee may be charged for patient registration.

All local and regional health departments have direct electronic access to TennCare eligibility information. TennCare eligibility (and MCO assignment and other third party status for current enrollees) must be checked on every TennCare patient for every visit during the registration process prior to any claim being sent to third party payers. When a TennCare-covered service is provided to a current TennCare enrollee, a claim for services should be generated.

Patients should be asked at the time every appointment is scheduled (or at the time of walk-up, if an appointment has not been made) if the patient is currently enrolled on TennCare or has other health insurance, or Medicare. The patient who states that he/she is not currently covered by TennCare or other health insurance will be considered private pay.

To initiate the verification, either the F4 TES (TennCare Eligibility Screen) or F5 TEH (TennCare Eligibility Screen) should be accessed. Only these two screens should be used to verify eligibility. If the patient is currently enrolled in TennCare, local health staff should determine the current MCO, using the F4 TES or F5 TEH screens, and up-date PTBMIS, if necessary. The SSN shown on the TennCare files for a patient currently enrolled, should be compared with the SSN entered in PTBMIS and any differences reconciled.

For current TennCare enrollees, the F4 TES screen must be accessed. If the letter Y is shown by the field TPL, this indicates the member has or had one other insurer besides the MCO. The F7 TPL/Medicare screen will provide the name, address and term of the member's private insurance. If the term of the private insurance policy is still current, either the claim must be denied by the private insurer(s) or TennCare will need documentation that the member is no longer covered by the primary insurer(s) before the MCO will be responsible for the charges.

A current member who has a Y shown by the field Medicare indicates the member is covered by both Medicare and TennCare. The Medicare fiscal agent is responsible for all medical services; claims for medical services provided to Medicare patients will be denied by the MCO. At most, the MCO is responsible for pharmaceuticals since Medicare does not cover the cost of drugs.

NECESSARY FORM

Informed Consent/Signature Sheet, PH-1530

REFERENCE DOCUMENTS

1. Rules and Regulations Governing Fees for Medical Care Services, Chapter 1200-17-2
2. DHHS Poverty Level Income Guidelines

3. Public Law 103-448 (WIC related)

OFFICE OF PRIMARY RESPONSIBILITY

Office of the Director, Bureau of Health Services, (615)741-7305