

# Change Page

## Section 7.9 -- Charges for Medical Services

Changes/additions are denoted in **gray highlight**. Deletions denoted as ~~strikethroughs~~.

REVISION DATE	CHANGE NUMBER	CHANGE
3/23/11	1	<a href="#">Click here for red letter edition</a>
01/15/2003	1	<p><b>PROCEDURE, paragraphs 4 &amp; 5:</b></p> <p>In order to become eligible for the sliding fee scale for <b>SERVICES WITH A FEE</b>, the patients must declare their <b>provide proof of income documentation to the local health department. A</b> at the initial visit, and each six (6) months thereafter. <del>, each patient who presents at the health department/clinic for services shall be given the opportunity to provide documentation about family income and family size for the purpose of applying the sliding fee scale.</del> Otherwise, the patient will be expected to pay 100% of the charges for the services provided. <b>PROOF OF INCOME</b> shall not be required except in clinics that are funded by federal grants requiring such (i.e. 330 RHI grantees). <del>If the patient provides updated information on any subsequent visit, appropriate action shall be taken regarding change of eligibility status for services and application of the sliding fee scale for services provided at that visit.</del></p> <p>Income information shall be recorded on the PTBMIS Financial Screen. The <b><u>Informed Consent/Signature Sheet, PH-1530</u></b>, must be signed by the patient. <del>Whenever new income or family size documentation is provided,</del> declared or documented, that information shall be updated on the PTBMIS Financial Screen and the <b><u>Informed Consent (PH-1530)</u></b> signed.</p> <p><b>CHANGE PURPOSE:</b> To move health departments from income documentation to income declaration, unless federal funders require income documentation for specific programs, such as WIC &amp; CSS or sites, such as 330 RHI grantees.</p>
12/01/2000	1	<p><b>PROCEDURE, Between 6th &amp; 7th paragraphs: Change from:</b> "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</p>

		<p>current charges and any outstanding balance.</p> <p>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."</p> <p><b>to</b></p> <p>"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.</p> <p><u>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.</u></p> <p>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."</p> <p><b>CHANGE PURPOSE:</b> Existing policy required either declaring income of paying full charge without slide and did not make an exception for minors. This was perceived to be a barrier to service for minor (&lt;21 years) and/or confidential contact family planning patients.</p>
3/13/2000	1	<p><b>PROCEDURE, 7th paragraph, 2nd sentence:</b> Change "Proof of income documentation will be required for <u>all</u> program services that use income to determine eligibility." to "Proof of income documentation will be required for WIC program services. Presumptive eligibility will be obtained by patient declaration."</p>
12/29/1999	1	<p><b>PROCEDURE, 4th paragraph:</b> Delete "At the initial visit, and each six (6) months thereafter, each patient who presents at the health department/clinic for services shall be asked to provide information about family income and family size for the purpose of applying the sliding fee scale. If the patient provides updated information on any other visit, appropriate action shall be taken regarding change of eligibility status for services and application of the sliding fee scale for services provided at that visit. Information shall be recorded on the <b>Informed</b></p>

		<b>Consent/Signature Sheet, PH-1530</b> , and signed by the patient."
12/29/1999	2	<p><b>PROCEDURE, after 3rd paragraph:</b> Add 4th-7th paragraphs: "In order to become eligible for the sliding fee scale, patients must provide proof of income documentation to the local health department. At the initial visit, and each six (6) months thereafter, each patient who presents at the health department/clinic for services shall be given the opportunity to provide documentation about family income and family size for the purpose of applying the sliding fee scale. Otherwise, the patient will be expected to pay 100% of the charges for the services provided. If the patient provides updated information on any subsequent visit, appropriate action shall be taken regarding change of eligibility status for services and application of the sliding fee scale for services provided at that visit.</p> <p>Income information shall be recorded on the PTBMIS Financial Screen. The <b>Informed Consent/Signature Sheet, PH-1530</b>, must be signed by the patient. Whenever new income or family size documentation is provided, that information shall be updated on the PTBMIS Financial Screen and the <b>Informed Consent (PH-1530)</b> signed.</p> <p>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.</p> <p>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 <u>all</u> program services that use income to determine eligibility."</p>
12/29/1999	3	<p><b>PROCEDURE, 12th paragraph:</b> Change "All local and regional health departments have direct electronic access to TennCare eligibility information. Accordingly, when a TennCare-covered service is provided to a current TennCare enrollee, a claim for services should be generated, but only after a member's eligibility and MCO have been verified and the existence of any other third party payers determined. At the very least, TennCare eligibility (and MCO assignment and other third party status for current enrollees) must be checked on every TennCare patient for every visit prior to any claim being sent to third party payers." to "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</p>

		current enrollees) must be checked on every TennCare patient for every visit 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."
12/29/1999	4	<b>PROCEDURE, 13th paragraph:</b> Change "In order to reduce the number of verifications that staff need to make, 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. The patient who states that he/she is not currently covered by TennCare or other health insurance will be considered private pay. There is no need to check this patient's TennCare eligibility." to "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. The patient who states that he/she is not currently covered by TennCare or other health insurance will be considered private pay."