PENDER COUNTY HEALTH DEPARTMENT

Title: Fee, Eligibility, and Billing Policy

Department: Fiscal Management

Effective Date: September 18, 2007

Last Revised: March 25, 2022

Approved by: Carolyn Moser 05/03/2022
Carolyn Moser Date
Health & Human Services Director

David Piepmeyer 5/2/22
David Piepmeyer Date
Board of Health Chair

Background and Purpose: To define the process of fees, eligibility, and billing for services rendered by Pender County Health Department.

Scope: Policy applies to all employees of Pender County Health Department that process fees, billing, and eligibility.

Policy: Public health services are increasingly costly to provide. The Health Department serves the public interest best by assuring that mandated public health services are furnished for all citizens and then providing as many recommended and requested public health services as possible for citizens with greatest need. We are here to promote health and wellness for the residents, by providing not only affordable, but quality healthcare. We are sometimes a place that the uninsured or underinsured turn to for services due to inability to afford services within a private practice. This policy is reviewed annually and revised as processes change.

Pender County Health Department provides services without regard to religion, race, color, national origin, creed, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, marital status, parity, or contraceptive preference. Services will not be denied based on inability to pay. PCHD utilizes the current, annually updated Federal Poverty Guidelines to determine the sliding fee scale.

FEES

Fees are a means to help provide services to citizens of the county and help finance and extend public health resources as government funding cannot support the full cost of providing all requested services in addition to required services. Fees are considered appropriate, in the sense that while the entire population benefits from the availability of subsidized public health services for those in need, it is the actual users of such services who gain benefits for themselves.

Fees for Health Department services are authorized under North Carolina 130A-39 (g), provided that 1) they are in accordance with a plan recommended by the Health & Human Services Director and approved by the Board of Health/County Commissioners, and 2) they are not otherwise

prohibited by law. Fees are based on the cost of providing the service. Fees collected (generated through reimbursement) will be maintained in an identifiable line item in the Health Department and the County Finance Office.

Fee Setting

In accordance with G.S. 130-A-39(g), which allows local health departments to implement fees for services rendered, the Pender County Health Department (PCHD), with the approval of the Board of Health/Board of County Commissioners, will implement specific fees for services and seek reimbursement for services. The method used for setting fees will be solely based on the cost to provide the service.

Fees will be determined based on the cost to provide services, in conjunction with the cost study analysis, which assesses direct and indirect costs including, but not limited to, the salary of staff rendering services, materials and supplies used, building and maintenance fees. In order to set fees, the Pender County Health Department will use multiple resources such as, the cost study analysis, fees of local health departments within the area and/or review the Medicaid, Medicare and Third Party Insurance rates for services.

A multi-disciplinary committee will meet at least annually and more often as needed to determine the cost of providing services and discuss the fees for the services provided. This committee is comprised of Program Supervisors, Lead Billing Clerk, Lab Manager, Business Officer, Director of Nursing and the Health & Human Services Director. The following procedures are followed:

- It is the responsibility of the Program Supervisor to bring to the attention of the committee any changes in costs for existing services or projected costs of new services.
- The Lead Billing Clerk notifies Program Supervisors and the DON of any changes in reimbursement for services from third-party payers, or projected reimbursements for new services.
- Changes in cost, changes in reimbursement, and new services/items are added to the meeting agenda to be reviewed for recommendations.

Once the fees are reviewed and discussed by the committee, the Health & Human Services Director will present the fees to the governing board during the budget process for their review and final approval. Once approval has been received, the appropriate fees are set and will be maintained in the Health Department, noted as the approved "Fee Schedule". The fee schedule may be automatically adjusted (without Board approval) during the fiscal year if the Health Department receives notification of an increase of the cost of supplies.

Vaccine and Administration

Pender County Health Department will not charge a fee to clients for state supplied vaccines provided to clients that are eligible for such vaccine in accordance to the NCIP Coverage Criteria and Vaccine for Children. Administration fees for the rendering of state supplied vaccine may be billed to Medicaid. State supplied vaccine will be identified with a SL modifier. The appropriate NDC code must also be included.

Clients and Third Party Payers may be charged and/or billed the administration fee and the cost of purchased vaccine by the Pender County Health Department as a non-sliding fee when provided outside of programs.

Vaccine administration and vaccine provided within Child Health, Family Planning, and Maternal Health program will be subject to the sliding fee scale.

340b Drugs and Devices

Pender County Health Department bills Medicaid the acquisition cost of medication or devices purchased through the 340b drug program. All 340b drugs and devices are identified with a UD modifier in the health department's billing system. 340b drugs and devices are billed to Medicaid with an FP and UD modifier. The appropriate NDC code must also be included. Drugs and devices purchased through the 340b program are labeled as 340b and stored separately from other medications and supplies.

Non-Sliding Fees

PCHD provides specific services at a non-discounted rate regardless of federal poverty level outside Child Health, Family Planning, Maternal Health and Communicable Disease programs. These fees will not be offered on a sliding fee scale. These fees include, but are not limited to TB skin test for employment or school, non-programmatic pregnancy tests, and purchased vaccine rendered outside of Child Health, Family Planning, Maternal Health and Communicable Disease. There is a mechanism in place for waiving fees of individuals who, for good cause, are unable to pay. This process is approved by the Health & Human Services Director or their designee. Waived fees will be documented in the Electronic Health Record with whom waived the fees and the reason for fees being waived.

Environmental Health Services Fees

Environmental Health fees are set based on comparison with surrounding counties and the cost to provide the service.

Dental Services Fees

Dental fees are set following the same approach as the clinic fees. The method used for setting fees will be solely based on the cost to provide the service. In addition to looking at surrounding counties' dental fees, local private practice fees are also used as a comparison.

Animal Shelter Fees

Animal Shelter fees are set based on comparison with surrounding counties and the cost to provide the service. In additional to looking at surrounding counties' shelter fees, local veterinarian fees are also used as a comparison.

ELIGIBILITY

Identification

It is considered "best practice" for each person presenting for services to establish identity either with a birth certificate, driver's license, military I.D., passport, visa, or green card, etc. The health department does not require a client to present identification that includes a picture of the client

for immunization, pregnancy prevention, sexually transmitted infection and communicable disease services (Consolidated Agreement).

Determining Family Size

A family is defined as a group of related or non-related individuals who are living together as one economic unit. Individuals are considered members of a single family or economic unit when their production of income and consumption of goods are related. An economic unit must have its own source of income. Also, groups of individuals living in the same house with other individuals may be considered a separate economic unit if each group supports only their unit. A pregnant woman is counted as two (including the unborn child) in determining family size unless it is in conflict with the clients cultural, religious, and/or beliefs.

Title X requires that any client seeking confidential services be considered a family of one and that only their income be used in assessing their percent pay on the sliding fee scale.

Examples		**Determining Family Size**
1	A foster child assigned by DSS with income considered to be paid to the foster parent for support of the child.	Family of 1
2	A student maintaining a separate residence and receiving most of her/his support from her/his parents or guardians. (Self-supporting students maintaining a separate residence would be a separate economic unit.)	Dependent of the family
3	An individual in an institution.	Separate Economic unit
4	A client who requests "confidential services", regardless of age.	Family of 1
5	If a Family Planning client presents for a service and is considered to be a minor or is covered by a parent's medical insurance policy, interview questions may include the following: *1) Ask the client if their parents are aware of their visit? 2) Ask if "both" parents are aware of their visit, since sometimes the mother may be present with the client, however, the father may not be aware of the visit. 3) Ask if you can send a bill to the home, to both parents.*	If the client states both parents are aware and it is not a confidential visit, you should treat as such and use all family members in the economic unit. If both parents are not aware, treat this as a confidential visit and use the income of the individual, counting the individual as a family of 1.

DETERMINING GROSS INCOME

Gross income is the total of all cash income before deductions for income taxes, employee's social security taxes, insurance premiums, bonds, etc. For self-employed applicants (both farm and non-

farm) this means net income after business expenses. Gross income will be used in fee determination and shall be defined as the combined cash income received by the client's family. Examples of sources of income and/or proof of income documentation are listed below.

1. Alimony
2. Bank Statement
3. Cash (any cash earnings, contributions received)
4. Check Stub (includes regular wages, overtime, etc.)
5. Child Support (cannot consider as income for Family Planning)
6. Client Statement
7. Disability
8. Dividends
9. Employment Security Commission
10. Income Tax Return (annual, not quarterly)
11. Letter of Verification from Employer
12. Military Earnings Statement
13. NC Unemployment
14. Pensions
15. Social Security
16. SSI
17. Tips

Exceptions

1. Payments to volunteers under Title I (VISTA) and Title II (RSVP, foster grandparents, and others) of the Domestic Volunteer Service Act of 1973
2. Payments received under the Job Training Partnership Act
3. Payments under the Low-Income Energy Assistance Act
4. The value of assistance to children or families under the National School Lunch Act, the Child Nutrition Act of 1966 and the Food Stamp Act of 1977
5. Veteran's Disability payments

No client will be refused services when presenting for care based on lack of income documentation. With the exception of Family Planning and Communicable Disease clients, each client will be billed at 100% until proof of income and family size is provided to the agency. The client will have 30 days to present this documentation in order to adjust the previous 100% charge to the sliding fee scale. If no documentation is produced in 30 days, then the charge stands at 100% for that visit. The charge may be adjusted if documentation is provided at a subsequent visit, not to exceed 90 days. The Family Planning Program will accept self-declaration of income. The Communicable Disease Program does not require income declaration. This does not apply to non-sliding fee scale services which should be paid in full on the date of service.

Computation of Income:

Income will be based on a twelve (12) month period. If the client is employed the day they present for a service, income will be calculated weekly, bi -weekly, monthly or annually, depending on the documentation obtained.

If the client is unemployed at the time he/she presents for services, their "employment only" income will be calculated at zero (0), however the client should be required to describe "their mechanism", in regard to costs for food, clothing, shelter, utilities, etc. Refer to "sources of income" counted and apply all sources, as appropriate. "Regular contributions received from other sources outside of the home" is most often considered one of those sources. If the client is receiving unemployment or other "sources" of income, as designated above, all of those sources should be counted.

	The client's income will be determined by the following:
Regular Income Formula: (Based on 12 month Period)	Use Gross Income or for self-employed income after business expenses. Weekly = pay x 52 Biweekly = pay x 26 Twice a month = pay x 24
Unemployment or Irregular Income Formula:	
Six months' formula (Based on 12 month Period)	• **Unemployed today** = last 6 months income + projected unemployment (if applicable) or zero if client wont' receive unemployment. This will give you income for the client for a 12 month period. o If no unemployment compensation – ask how the client is going to support themselves. • **Employed today but unemployed last 6 months** – Did the client receive unemployment the last 6 months? In no, record as zero and then project 6 months forward at current income. This will give you income for the client for a 12 month period.

Income is re-assessed annually unless there has been a change in financial status. Following the initial financial eligibility determination, the client will be asked at each visit if there has been a change in their financial status. Income will always be based on the "actual date" of service. If there has been a change or it is time for their annual review, the income determination process should take place. Income information reported during the financial eligibility screening process for one program can be used through other programs offered in the agency, rather than to re-verify income or rely solely on the client's self-report. Exception to the rule, effective November 8, 2021, for family planning, if income was not provided and the client was charged at 100% previously, clients will **not** automatically be charged at 100% in family planning.

The number in the household, annual gross income and percentage of pay will be documented in the Household Income section of the EHR and electronically signed by the client.

Client fees are assessed according to the rules and regulations of each program and the recommended Program's Poverty Level Scale (Sliding Fee Scale) will be used to assess fees. All third-party providers will be billed, without discount, where applicable.

Healthy Mothers Healthy Children (HMHC)/Title V (Well-Child Funding)
Title V policy on applying sliding fee scale: any client whose income is less than the federal poverty level will not be charged for a service if that service is partly or wholly supported by Title V funds. For clients having income above the federal poverty level, the sliding fee scale of the Pender County Health Department will be used to determine the percent of client participation in the cost of the service.

The guidance regarding Title V funding and sliding Child Health services to zero is as follows:
Any Maternal and Child Health services (even outside of Child Health Clinics) must use a sliding fee scale that slides to "0" at 100% of the current, updated annually, Federal Poverty Level per the NC Administrative Code – 10A NCAC 43B.0109 Client and Third-Party Fees.

The NC Administrative Code goes beyond the Title V/351 AA requirements, that all child health services, whether sick or well, no matter where delivered, must be billed on a sliding fee scale that slides to zero.

10A NCAC 43B .0109 CLIENT AND THIRD-PARTY FEES

(1) If a local provider imposes any charges on clients for maternal and child health services, such charges:
   (a) Will be applied according to a public schedule of charges;
   (b) Will not be imposed on low-income individuals or their families;
   (c) Will be adjusted to reflect the income, resources, and family size of the individual receiving the services.
(2) If client fees are charged, providers must make reasonable efforts to collect from third party payors.
(3) Client and third-party fees collected by the local provider for the provision of maternal and child health services must be used, upon approval of the program, to expand, maintain, or enhance these services. No person shall be denied services because of an inability to pay.

History Note: Authority G.S. 130A-124; Eff. April 1, 1985; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. October 3, 2017

Child Health funds may not be used to supplement Medicaid services, support services or activities supported by other Agreement Addenda, and may not support services and activities that have not been approved by the C&Y Branch.

Child Health/Health Check
Well child exams (Health Check) conducted by FNP; exam includes medical, social, development, nutritional history, lab work, physical exam and immunizations as needed.

Primary Care (Child Health) for sick children provided by FNP.
Eligibility: birth to 20 years; Child Health/Primary Care: 101% - 250% Federal Poverty Scale; Medicaid, or Insurance

Maternal Health
Prenatal care for eligible pregnant women.
Eligibility: Must be a Pender County resident: 101% - 250% Federal Poverty Scale; Presumptive Medicaid, Medicaid or Insurance.

Proof of Residency
Proof of residency is required in the Maternal Health Program. Proof of residency must be a least one acceptable form such as:

- Mortgage or rental agreement
- Utility bill such as electric, gas, phone, water, cable (less than 60-days old)
- Bank Statement
- Pay check stub (less than 60-days old)
- Driver's license or DMV identification
- If no proof of residency is available due to theft, loss or disaster, homelessness, migrant, or a transfer with no proof, document the reasons for no proof of residency in the Patient Notes. Upon subsequent visit, request an acceptable proof of residency.

Family Planning or Women's Health Services
Clinic designed to assist men and women, including adolescents, with their family planning needs; services include, but are not limited to detailed history, lab work, physical exam, counseling and education given by nurse or provider. All family planning services are client centered, culturally and linguistically appropriate, inclusive, and trauma informed.
Eligibility: Men and Women of childbearing age regardless of residency: 101-250% Sliding Fee Scale is applied; Medicaid or Insurance.

The following shall apply to Family Planning clients:
(1) Clients may not be coerced to use contraception, or to use any particular method of contraception or service.
(2) If a client, including adolescents, is seeking confidential services, they will be considered "confidential" and the visit note for that day of service will be marked confidential. Charges to clients seeking confidential services will be based solely on the individual's income.
(3) Confidential clients will NOT be referred to Debt Set-off.
(4) The "Bad Debt Write-Off" method of aging accounts will be strictly followed. The list of bad debts will be approved by the Health & Human Services Director, prior to submission to the Board of Health. Bad debts will not be written off until the approval of the Board of Health has been acquired. Board of Health meeting minutes will serve as documentation that the write-offs have been approved.
(5) Bills/receipts will be given to clients at the time of service show total charges, as well as any allowable discounts.

(6) Where a third party is responsible, bills are submitted to that party. Bills to third parties show total charges, without discounts, unless there is a contracted reimbursement rate that must be billed per the third-party agreement.
(7) Verbal declaration of income is accepted for Family Planning clients.
(8) If a Family Planning client refuses to provide a verbal declaration of income, and income cannot be verified through access to enrollment in another program within the health department, the client will be charged 100% of the cost of services, after informing the client that failure to declare income will result in the client owing 100% of the fee.
(9) Family Planning clients will pay the lesser of the copay and additional fees or where they fall on Sliding Fee Scale as required by Title X.

Communicable Disease Control
This program deals with the investigation and follow-up of all reportable communicable and/or sexually transmitted diseases, to include: testing, diagnosis, treatment, and referring as appropriate. It also provides follow-up and treatment of TB cases and their contacts.
Eligibility: No residency requirements. No fees charged to the client for these services as stated in program rules. Medicaid and Insurance can be billed unless this would result in breach of confidentiality and the client requests no third-party billing. All laboratory tests processed by the state lab will be provided at no charge.

Breast and Cervical Cancer Control Program (BCCCP)
Provides pap smears, breast exams and screening mammograms, assists women with abnormal breast examinations/mammograms, or abnormal cervical screenings to obtain additional diagnostic examinations.
Eligibility: determined by specific policies and procedures including income guidelines defined by the Breast and Cervical Cancer Control Program (BCCCP). 101-250% Sliding Fee Scale Applied.

Other Services
The Sliding Fee Scale does not apply to all health department services. Services with non-sliding fees do not require proof of income.
Adult Health/Primary Care – Sliding to 30% of 250% Federal Poverty Scale (minimum fee)
Dental Clinic Services – Sliding to 40% of 250% Federal Poverty Scale

Women's Infants and Children's Nutrition (WIC)
Supplemental nutrition and education program to provide specific nutritional foods and education services to improve health status of target groups.
Eligibility: WIC is available to pregnant, breastfeeding, and postpartum women as well as infants and children up to age 5. The following criteria must also be met: 1) be a resident of Pender County; 2) be at medical and/or nutritional risk; 3) have a family income less than 185% of the US Federal Poverty Level; Medicaid, AFDC, or food stamps automatically meet the income eligibility requirement.

Billing & Revenue

In accordance with G.S. 130-A-39(g), which allows local health departments to implement a fee for services rendered the Pender County Health Department, with the approval of the Pender County

Board of Health/County Commissioners will implement specific fees for services during the budget process and seek reimbursement. Specific methods used in seeking reimbursement will be through third-party coverage, including Medicaid, Medicare, private insurance, and individual client. Pender County Health Department currently participates with Medicare, Medicaid, State Health Plan of NC and a variety of private insurances. The agency will adhere to billing procedures as specified by Program/State regulations in seeking reimbursement for services provided.

Charging for Services

1. There shall be no minimum fee requirement or surcharge that is indiscriminately applied to all clients.
2. Persons requesting program services will be encouraged to apply for Medicaid.
3. Charges will not be assessed when income falls below 100% of Federal Poverty Guidelines, for Child Health, Family Planning and Maternity programs.
4. There shall be a consistent applied method of "aging" accounts.
5. No one shall be denied services based solely on the inability to pay.
6. Clients shall be given a receipt each time a payment is collected
7. Donations shall be accepted, regardless of income status if they are truly voluntary. The client's account balance will not be reduced due to a donation. There shall be no "schedule of donations", bills for donations, or implied or overt coercion.
8. Provider will use best efforts to continue to provide services to clients at or below 150% of Federal Poverty Level.

Fee Collection

1. Charges in all programs will be determined by a fee scale based on the current Federal Poverty guidelines with the exception of any services deemed as non-sliding fees. (i.e. TB skin test, Non-programmatic pregnancy tests, Adult Health and Dental Services).
2. Upon each clinic visit, Management Support staff will determine the income and sliding fee scale status of each client. Staff will be responsible for documentation of financial eligibility under the Household tab in the EHR. With the exception of family planning, clients without required verification will be charged at 100% until income documentation is received.
3. Payment is due and expected at the time services are rendered. If a balance remains, a payment agreement and schedule will be established and signed by the client. (See Attachment D)
4. Adult Health clients who are self-pay are required to make a minimal payment upfront for preventative visits, sick visits, and labwork.
5. There is a mechanism in place for waiving fees of individuals who, for good cause, are unable to pay. This process is approved by the Health & Human Services Director or their designee, and each instance of fee waiver shall be documented in agency records and communicated to the client according to protocol.
6. Enrollment under Title XIX (Medicaid) shall be presumed to constitute full payment for billable services to Medicaid.
7. The Accounts Receivable System will be balanced daily.
8. Emergency services will never be denied.
9. Monthly statements will be mailed to the client/responsible party as long as confidentiality is not jeopardized.

Billing Medicaid and Third-Party Insurance

1. Clients presenting with third party health insurance coverage where copayments are required shall be subject to collection of the required copayment at the time of service. For Family Planning (Title X) clients, the copay/deductible may not exceed the amount they would have paid for services based on the sliding fee scale.
2. Clients will sign an electronic consent allowing the Health Department to file insurance and a copy of the insurance card will be scanned at that time into the client's medical record.
3. Third party is billed the total amount of the service provided. The charge and any remaining balance with the exception of copayments, is billed to the client based on the sliding fee scale. Copayments are not subject to the sliding fee scale, except that Family Planning clients may not be charged more in copayments and deductibles than they would have been responsible for on the sliding fee scale.
4. Claims are filed electronically via the clearing house of the EHR.
5. Payments are posted electronically/manually to client accounts. If applicable, secondary insurance is filed.
6. Denials are researched using the Remittance Advice (RA) for Medicaid and Explanation of Benefits' for private insurance. Any denials deemed incorrect are resubmitted as quickly as possible. Any remittance or final denial is posted to the client's account. Remaining balance for Medicaid clients are adjusted off. (unless it was for a non-covered service that the client was made aware of prior to the service being rendered.)
7. If a client has any form of third-party reimbursement, that payer must be billed with the patient's consent, unless confidentiality is a barrier*. Medicaid will be billed as the payer of last resort. Clients should be made aware that they will be responsible for any balance remaining after the claim has been processed. This may include copays, coinsurance, deductibles and non-allowed charges. As required by Title X, Family Planning clients whose family income is between 101%-250% FPL will not pay more in copayments or additional fees than they would otherwise pay when the schedule of discounts is applied.

8. If an encounter with a client is found to be coded incorrectly, the provider may make corrections by appending the provider's note and e-superbill within the client's medical record and notifying the billing department. The billing department will review the corrections and update the charges accordingly. If a client has been charged and have received a monthly statement and the addition or correction of the service made by the provider will increase the client's balance, the correction will be made with no additional cost to the client, unless, the client was over charged.

* Third party billing is processed in a manner that does not breach client confidentiality, particularly in sensitive cases (e.g., adolescents or young adults seeking confidential services, or individuals for whom billing the policy holder could result in interpersonal violence). The confidential client may give you their insurance card not thinking that the subscriber is not aware of the visit. Filing an insurance claim will result in an EOB (explanation of benefits) being sent to the subscriber which would violate confidentiality. Be certain to have the client sign/initial if they want insurance to be filed.

All clinic and in-house laboratory fees will be collected as part of the check-out process by the health department billing staff. Laboratory fees for self-pay patients receiving out-sourced testing

will be collected by the billing staff upfront. Out-sourced labs for patients with Medicaid or other third party insurance will be billed directly by the private laboratory. The private laboratory will bill patients for any remaining balances according to their standard fees. Exception: If a lab is ordered in the Family Planning Program, the private laboratory will bill the health department directly and the fee will be billed to the patient on sliding fee scale. All in-house labs will be billed on sliding fee scale.

Private Vaccines Administered in General Clinic
Payment in full is required at the time of service for vaccines not supplied by the State, with exception of those billed to contracted in-network third party payers. These include Medicaid, Medicare Part B, Medicare Part D (via TransactRX), Health Choice, BCBS, etc. Patients with coverage outside of health department's network of third party payers will be provided a receipt for submission to their insurance carrier.

Newborn/Postpartum Home Visits, High-risk Prenatal Home Visits, Diabetes Education Classes
Visits and classes will be billed to Medicaid. For non-Medicaid patients, Diabetes Education classes will be billed to insurance. If uninsured, services will be billed to the client at the Medicaid reimbursement rate and the sliding fee scale applied.

Environmental Health Services
Payment is required prior to the provision of these services. Fees must be accompanied with the appropriate application and any other necessary documents or maps, and are payable in the Environmental Health offices, over the phone via credit card and through the U.S. Post Office. Staff SHALL NOT accept or agree to transport any payment of fees while conducting field work.

Fees are collected and recorded by management support staff in the office during the hours of 8:00 a.m. until 5:00 p.m. A receipt shall be issued for each fee collected. In the event that all management support staff are away from the office for a period of time during the specified hours, an Environmental Health Specialist shall be designated by Environmental Health administration to accept applications, collect fees and issue receipts.

Animal Shelter Services
The animal shelter does not utilize income-based payments. Everyone is charged according to the set fees regardless of income or ability to pay.

Overpayments and Refunds
Payment for copays, deductibles, coinsurance, account balances and non-sliding fees will be collected at the time of service. If an overpayment is made by the client, the client will be notified of the overpayment and given the option for refund, or application of the overpayment to another date of service balance or for an upcoming appointment. Overpayments that clients choose to have refunded, will be refunded based on county policy.

Overpayments paid by Medicaid, Medicare and insurance will be reviewed and refunded in accordance to the guidelines set forth in our network participatory agreement.

Bad Debt Write Off

- An itemized list of uncollectable outstanding patient balances will be prepared at the end of the calendar year for the Director of Health & Human Services to review. This list includes all outstanding accounts that reflect no activity for more than 12 months.
- Those balances approved by the Health & Human Services Director and the Board of Health will be written off.
- The Accounts Receivable system shall indicate the recording of the bill as uncollectable by adjusting the patient balance to zero. Claims will be kept on file.

Family Planning patients will not be denied services for inability to pay. Payment arrangements will be made for all outstanding bad debt and any current unpaid balances for Family Planning services.

If a patient returns to the health department after a bad debt has been determined uncollectable, their bad debt write off will be reactivated and the billing process resumed. The patient's account balance will be reinstated at the full amount of the write off.

A patient should never be informed that a debt has been written off.

Limiting or Restricting Services

- Women's Health: The Title X guidelines do not distinguish between "inability" and "unwillingness" to pay. For Family Planning clients who do not pay, the health department can use debt set-off. Even if a client establishes a payment plan but then refuses to honor the plan services cannot be denied or restricted.
- In Maternal Health, denying or restricting services would constitute client abandonment. Therefore, services for Maternal Health may not be denied because a client is unwilling or unable to pay.
- Child Health may not restrict Child Health services due to an outstanding bill. Title V funds are used to prevent barriers to care for clients that are Non-Medicaid, non-insured as well.
- The Health & Human Services Director has the authority to waive or reduce fees for special projects or targeted populations. The Health & Human Services Director has the right to waive fees for individuals who for a good cause are unable to pay. If collection procedures have been followed without success, the Billing Department may submit the individual's statement of charges along with an explanation of his/her situation to the Health & Human Services Director and request a waiver of charges. The Health & Human Services Director will review the circumstances and make an approved or not approved notation on the statement, along with the date and his/her signature. Billing will scan this record into the patient's chart and attach it to the charges that were waived or not waived.

No Mail Policy for Confidential Clients

1. When a client requests no mail, discussion of payment of outstanding debts shall occur at the time service is rendered.
2. If the client is unable to pay in full at the time of service rendered, a receipt will be given to the client reflecting the partial payment and the client will sign a payment agreement.

3. Medical record is flagged reflecting-- **"NO MAIL" and every precaution should be taken to ensure bills are "not" sent to clients, requesting "NO MAIL".**
4. Client is reminded every visit of the amount they still owe.
5. No letters or correspondence concerning insurance, past due accounts or other billing issues will be sent to any client that requests "NO MAIL".

HEALTH PROMOTION SERVICES

SMOKE FREE RESTAURANT FINES

Upon notification in writing of the third violation of the Act to Prohibit Smoking in Certain Public Places and Certain Places of Employment in accordance with G.S. 130A-22 (h1), the Pender County Health Department shall impose an administrative penalty of $200 on the person who manages, operates, or controls the business in violation.

The person who manages, operates or controls the business has the right to appeal this decision to the local Board of Health. To pursue a formal appeal, a written notice of appeal must be submitted to the Health & Human Services Director within 30 days of notification of the third violation. The notice of appeal must be filed in accordance with G.S. 130A-24. A copy of the appeal procedures shall be provided.

Subsequent violations of the law are considered separate and distinct violations and the person who manages, operates or controls the business in violation is subject to an administrative penalty of not more than two hundred dollars ($200). Each day on which a violation of this law or rule occurs may be considered a separate and distinct violation.

Payment for Smoke Free Restaurant fines shall be made within 30 days of the date of notice, unless an appeal has been filed. For appealed fines, payment shall be made within 30 days of the appeal decision.

Pender County Health Department

CLIENT BILL OF RIGHTS

1. The PATIENT has the right to considerate and respectful care.

2. The PATIENT has the right to obtain from his/her medical provider complete and current information concerning diagnosis and treatment, in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person on his/her behalf. The patient has the right to know by name the medical provider responsible for coordinating his/her care.

3. The PATIENT has the right to receive from his/her medical provider information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include, but not necessarily be limited to, the specific procedure and/or treatment and the medically significant risks involved. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment.

4. The PATIENT has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action.

5. The PATIENT has the right to every consideration of his/her privacy concerning his/her own medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. Those not directly involved in direct care must have the permission of the patient to be present.

6. The PATIENT has the right to expect that all communications and records pertaining to his/her care should be treated as confidential.

7. The PATIENT has the right to expect that within its capacity any agency must make reasonable response to the request of a patient for services. The agency must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another agency only after he/she has received complete information and explanation concerning the needs for and alternatives to such a transfer. The agency to which the patient is to be transferred must first have accepted the patient for transfer.

8. The PATIENT has the right to obtain information as to any relationship of the agency to other similar agencies and educations institutions insofar as his/her care is concerned. The patient has the right to obtain information as to the existence of any professional relationship among individuals, by name, who is treating him/her.

9. The PATIENT has the right to expect reasonable continuity of care. He/she has the right to know in advance what appointment times and health care providers are available.

10. The PATIENT has the right to examine and receive an explanation of his/her bill regardless of source of payment.

11. The PATIENT has the right to know what the health department rules and regulations are that apply to his/her conduct as a patient.

The Pender County Health Department staff provides safe and individual patient care based on each patient's needs and rights through:

- Recognition of each patient's dignity as a human being, and
- Defending the rights of each patient as an advocate.

The observance of these rights is expected to contribute to quality patient care and greater satisfaction for the patient and health care provider.