

Q&A from Local Health Department Finance & Billing Principles
April/May 2017

Debt Setoff

1. *Does the debtor have to be a North Carolina resident? For example, will the state set off a debt for a non-NC resident who wins the lottery?*

The debtor does not have to be a NC resident. A local government can submit a non-resident and most do. Especially from border states. Often a person moves back to the state of NC.

2. *When a DSO payment goes to a county, is it divided by department? Or does the county divide the payment by department?*

The deposit is made into one account at N.C. Capital Management Trust. However, most counties do separate by department. The Clearinghouse software and other files that they provide helps identify how much is for each department.

3. *Can agencies use clearinghouses other than Five Star Computing to submit claims to NC Debt Setoff?*

Local governments in North Carolina must use the NC Debt Setoff Clearinghouse (Five Star Computing).

4. *Is there an issue with HIPAA since our debts go through our county office and they can see our patients' names?*

According to Bill Walsh, President of Five Star Computing: "If they use our software we can protect so that Tax office can't see full SSNs. But we have lots of Counties submitting Health debts. I'm not sure what type of restrictions/policies the counties work under for protection." Additional questions should be addressed to Bill Walsh or your agency HIPAA Privacy Officer.

5. *Can districts participate in NC Debt Setoff?*

Several districts already participate in NC Debt Setoff. Two are registered as Category 9 – Joint Regional Agencies. Four are registered as Category 6 – Public Health Authorities.

6. *If we submit a debt using a child's SSN, will it be matched to the parent's refund (since the child's SSN is on their return) and setoff?*

No, the debt must be submitted with the parent/guardian SSN and Name. The Dept of Revenue does not link to dependent SSNs.

7. *How should Debt Setoff balances be identified on the patient's ledger?*

There should be a separate guarantor for Debt Setoff balances. Debt Setoff balances should not be removed from the patient's ledger. They should be transferred to the Debt Setoff guarantor.

8. *If the patient is making payments, can we send them to Debt Setoff?*

The Clearinghouse requires a debt to be sixty (60) days delinquent before the required notification letter is sent.

9. *Can Confidential Contact patients be sent to Debt Setoff?*

Patients who have requested no mail should not be submitted to Debt Setoff.

10. *What if the worker name and worker Social Security number is different than the patient's name?*

The claim will be filed against the social security number that is submitted to Debt Setoff.

11. *Do we need a Business Associate Agreement with our county tax office, since they key our information?*

Yes.

12. *Does Debt Setoff ever withhold more from the patient than is owed?*

The setoff amount may be more than the actual Health Department debt because of the setoff fees which are withheld. They may also have debt at other county agencies which was submitted for payment.

13. *Can a current balance be combined with a balance that was previously written off?*

Your agency should have a written policy addressing submission of debts that were previously written off. If your agency submits written off debt, the debt should be reinstated and then submitted to Debt Setoff. Your agency's policy should include a maximum age for reinstating the written off debt. Consult your county attorney regarding your county's definition of when a debt is too old to submit to Debt Setoff.

Patient Fees and Charges

1. *If there is an old balance for a Child Health patient and the patient is now an adult, who gets the statement?*

The parent is still responsible for the bill. The child did not sign for responsibility.

2. *If a Family Planning patient does not provide proof of their parents' income, do we charge 100%?*

If verification is available and the patient is willing to furnish verification, you should charge 100% until verification is provided. If the patient is not willing to ask her parents for verification, you should accept verbal declaration rather than create a barrier to care. This should be addressed in your agency's written policy.

3. *Can we have a clause in our policy that minor Family Planning patients do not have to provide proof of income but may declare income?*

Your policy should address all Family Planning patients living with their parents rather than "minor" patients, which could be interpreted as age discrimination. Your agency may have a policy addressing declaration of income (see question above).

4. *Can Returned Check fees be charged to the patient?*

Although the April 26, 2017 memo from Kelly Kimple through Belinda Pettiford did not specifically address returned check fees, we have been told that returned check fees should be treated the same as Credit Card Processing Fees and Late Fees. Returned Check fees may be charged to families who are being billed for services on a sliding fee scale. Your agency's policy should address how returned check fees are charged and should ensure that they are not charged in a manner that would create barriers to access of care.

5. *Does a pregnant woman have to be counted as two family members?*

We are unaware of any specific DPH program guidance which requires counting a pregnant woman as two. However, Medicaid counts a pregnant woman as two. To be consistent with Medicaid, most agencies follow this same practice.

6. *If a patient has Be Smart Medicaid Coverage (Family Planning Waiver), can we charge a flat rate for her pregnancy test?*

Be Smart (FPW) will pay up to six pregnancy tests per year when they are related to the patient's birth control method and provided in the Family Planning clinic. If the patient requests a pregnancy test that is not related to her method and is not part of a Family Planning visit, then FPW will not pay. All services provided in the Family Planning clinic are required to slide. Some clinics do not require a sliding fee scale. If a FPW patient will be charged for a service which is

not covered by Medicaid, she must be informed before receiving the services that she will be responsible for payment.

7. *Do outside labs need to be included in the Super Bill?*

All services provided to the patient should be recorded on the Super Bill. Modifier 90 indicates that a lab test was performed at an outside lab.

8. *For Communicable Disease, can we bill Medicaid if we do not bill insurance?*

Because there is no EOB, we do not have to get permission from the patient to bill Medicaid for Communicable Disease services. Patient consent is required to bill insurance. If the patient refuses consent to bill insurance, then you most likely will receive a denial from Medicaid because they are the payor of last resort.

9. *Can we charge a flat fee for sports physicals?*

All services for children must slide. Current recommendations are that you use CPT codes rather than LU codes where possible. This includes physicals and possibly other services. You must follow appropriate Child Health guidelines when performing these services to children. Any primary care services provided to children should be coded to Child Health. You should charge your usual and customary charge for the service and slide any services provided to children. Contact your Child Health Nursing Consultant for specific guidance. Also see memo from Phyllis Rocco, PHNPDU, LTAT Branch Head which is in the June 2017 Coding & Billing Guidance Document on page 27.

10. *Can we charge a flat fee for Adult Health physicals?*

Current recommendations are that you use CPT codes rather than LU codes where possible. Some clinics which provide services to adults do not require a sliding fee scale. All services provided through WCH programs must slide.

11. *Are agencies required to provide services to patients who live outside of North Carolina?*

Yes, for those programs that do not allow residency restrictions.

12. *Is Veterans Disability counted as income?*

Probably not. The Internal Revenue Service has provided information on their website about excluding Veterans Disability as income. Your agency should have a written policy addressing Veterans Disability, based on research and the current guidance provided by the Internal Revenue Service.

13. *What constitutes an economic unit?*

Individuals are considered members of a single economic unit when their production of income and consumption of goods are related. A separate economic unit must have its own source of income.

14. *Is it mandated that we use a third-party letter to verify income?*

No, it is not mandated; but, it is best practice for getting correct income information.

15. *Is the rule about charging the lesser of the insurance copay or the patient's charge based on the sliding fee scale specific to Family Planning?*

Family Planning is the only program with this requirement. However, your agency might consider applying the rule to all programs for consistency.

16. *What does "Confidential" mean?*

All Health Department patients are confidential in the sense that we do not discuss anything about their visits without their written consent. The actual question to determine Confidential Status for billing purposes is “can we send mail to your home address”. If the patient indicates that they do not want to receive mail at their home address, then they are considered “Confidential” and income should be assessed according to your agency’s written policy. Any patient, regardless of age, who requests no mail should be considered “Confidential”.

17. *If a confidential Family Planning patient becomes pregnant, can she still request Confidential status?*

Yes. Remember that “Confidential” means that she does not want to receive mail at her home address. Your agency policy should address any patient who requests confidential status, not just Family Planning patients. If your agency’s policy says that a pregnant woman counts as two, she would be counted as a family size of two and only her income would be used to determine her sliding fee scale percentage.

18. *Do we bill Medicaid or Insurance for confidential patients?*

Because no EOB is mailed to the home for Medicaid claims, we can bill Medicaid. We can only bill insurance if the patient signs a consent, which they may not do if they do not want an EOB going to their home address.

19. *Several insurances are set up as “Confidential” in Patagonia and will not send an EOB bill. Can we bill services for a patient with Confidential Status to one of these insurance companies?*

The patient is required to sign a consent for us to bill insurance. If the insurance company mails an Explanation of Benefits to the patient’s home, or makes the information available online, she may not want to sign a consent. We need to do everything possible to safeguard our confidential status patients from any possibility of any type of mail going to the home address.

20. *We have a provider in the back who tells patients to request confidential status so they will not receive a bill. What can we do about that?*

The patient may still owe for services based on her income. All Health Department employees should be aware that most LHDs no longer receive the state and county funding that was provided in earlier years. To continue providing services *and employing staff*, most LHDs have become very conscious of costs and revenue streams. This might be a good time for your agency to consider Practice Management consultation. There is information on the DPH website about first steps for requesting Practice Management Consultation.

21. *When the patient returns to check out after the visit, the nurse has indicated “No Mail” on the patient’s chart. What do we need to do?*

Re-interview the patient to see if she desires confidential status or not. If so, follow your agency’s policy concerning household size and income.

22. *Local Health Departments are prohibited by state law from billing for STD screenings. Can we bill patients for tests not offered by the NC State Lab or procedures not required by the DPH STD program?*

Yes. This should be included in your agency’s written policy. The policy should address whether a sliding fee scale is applied to the charge for these services.

23. *If the patient is covered by insurance and gets a lab test that is processed at an outside lab, can the outside lab bill the patient if insurance does not pay?*

The determination of whether the outside lab directly bills the patient's insurance or whether the lab bills the LHD at a contracted rate needs to be worked out between the LHD and the outside lab. Remember that services related to WCH programs will have to slide.

24. *Can we charge J3490 for Plan B emergency contraception?*

Please check the Women's Health Summer 2017 NCAPHNA Report for guidance about billing for Emergency Contraception. Because J3490 is used in other programs for other drugs, they suggest that agencies consider using HCPCS code S5001 ("prescription drug, brand name") for Ella and Plan B or HCPCS code S5000 ("prescription drug, generic") for generic emergency contraception drugs. Medicaid will not reimburse LHDs for emergency contraception.

25. *Can we use 340b drugs for NC Health Choice patients?*

Yes, per Medicaid's Family Planning Policy 1E-7 1.1.1 Regular Medicaid Family Planning (Medicaid FP) and NCHC.

26. *Tricare has a tendency to pay claims and then recoup later. Do we bill the patient?*

The patient must be notified before receiving the service that they might be responsible for the charge. If the patient is notified and insurance recoups the payments, then you can charge the patient. The charge should be based on their sliding fee percentage if the services were provided in a program which uses a sliding fee scale.

27. *What if the insurance recoupment is more than a year later?*

Your written policy should address any time frame restrictions. If the patient was advised before receiving the service that he/she would be responsible for any charges not paid by insurance, then you can bill the charge to the patient. If your agency decides to impose a time frame for good will reasons, then your agency's policy will need to reflect that practice.

28. *When does a signed insurance consent expire?*

You may add the following statement to your insurance consent. "This assignment will remain in effect until insurance information changes or revoked in writing by the patient or their authorized representative".

29. *What if we don't have a contract with the patient's insurance carrier?*

The patient should be informed that we are not a participating provider. They should be encouraged to seek care from a participating provider. Should they choose to receive services from us, they should be billed on the sliding fee scale. They must be informed before receiving the service that they are responsible for the charge.

30. *Can the patient be billed for a Communicable Disease test if the state lab does not provide the test?*

Per the Coding and Billing Document published on the DPH Website, if the state lab does not provide a test, insurance can be billed with the patient's consent and patients without insurance or who do not want to file with their insurance can choose to pay out of pocket. This should be included in the LHD written policy.

31. *Can we bill the patient if Medicaid denies payment because her physical was less than 365 days from her last physical?*

If the patient was informed before receiving the service that they would be billed if Medicaid denied the service due to paying another physical within 365 days, then the patient can be billed on the sliding fee scale. For patients who are new to your agency you should make an effort (request records from previous provider, etc.) to determine the last physical date. For established patients, you should ensure that their physical appointment is more than 365 days from the last physical. Each Health Department should have a written policy stating whether your agency will bill patients for these services or absorb the cost.

Fee and Eligibility policy

1. *Does proof of identity have to be issued by state or federal government?*
It is according to your local agency's written policy as to what is acceptable as proof of identity.
2. *If a patient refuses to provide income information, how should they be charged?*
You should follow your agency's written policy. If stated in policy, they could be charged 100% until income information is provided.
3. *Single county agencies are required to have their policies approved by the Board of Health and the County Commissioners. Is this also required for District Health Department Agencies?*
Yes.
4. *Can we use a generic insurance consent form, or does it have to be specific?*
It is best practice to use a consent form which specifies the name of the insurance company.

Presumptive Eligibility

1. *Can anyone complete the Presumptive Eligibility form?*
No. You have to be trained and signed off to complete the applications. Check with DSS for training.
2. *Is it required to do Presumptive early in pregnancy?*
Women's Health wants us to do presumptive "early in pregnancy". If the patient is transferring to another provider, presumptive eligibility should be completed at the positive pregnancy test visit. This will ensure that she is covered in the event of problems. If the patient plans to attend your agency's Maternity Clinic, presumptive eligibility can be completed at the initial Maternity intake visit.
3. *Is there a time limit for DSS to determine eligibility?*
Yes. They are required to respond within 45 days. Contact DSS if your agency is having issues.
4. *Should we complete a Presumptive Eligibility application for patients already receiving Medicaid?*
No. The patient should notify her DSS social worker that she is pregnant.
5. *Why does it matter whether DSS or the Health Department completes the Presumptive Eligibility application?*

Health Departments can accept declaration of income. DSS requires proof. Health Departments do not verify citizenship. DSS keys Presumptive Eligibility into their system after the 5th day of the following month. If the patient is determined not eligible, we may get more coverage time if we complete the application.

6. *If we do the Presumptive Eligibility application, should the patient go to DSS?*

No. If the patient goes to DSS, she may be denied and would not be eligible for 45 days of presumptive coverage.

Service Denials and Restrictions

1. *If LHD has seen patient for prior pregnancy, can they deny admission to clinic for another pregnancy?*

You are not obligated to see the patient for another pregnancy just because she attended your clinic for her last pregnancy. However, once she has been admitted to the Maternity Clinic, to deny services is considered abandonment and is not allowed. If there are no other alternatives for affordable prenatal care in your area, you should admit the patient to your clinic based on the requirement that LHDs assure prenatal services to uninsured patients.

2. *Can we deny services to Adult Health patients who are less than 100% of poverty?*

We are not aware of rules that require agencies to provide services to Adult Health patients.

3. *If a Family Planning patient owes money, what can be done?*

You cannot refuse service. Family Planning program makes no distinction between an inability to pay and unwillingness to pay. You should monitor the debt until it meets the requirements of your agency's Bad Debt Write Off Policy, at which time the debt can be written off. If the patient is not confidential and your agency's Debt Setoff Policy does not restrict submission of Family Planning patients, the debt can be submitted to Debt Setoff for collection.

4. *Are we obligated to provide services to patients who have been classified by our agency as "dangerous"?*

As long as the situation is documented and your agency's legal advisor is notified, you are not obligated to serve patients who have threatened staff or other patients. This should be addressed in your agency's written policy.

Consolidated Agreement and Program Addenda

1. *Are Funding Authorizations available online?*

Unfortunately, they are not all available at one site. Some are available on the individual program's website.

2. *Are CFDA number available online?*

Yes. In WIRM, click on "Reports" and click on "Key Audit". In addition to the CFDA#, there is also a column indicating whether the funding was state or federal.

3. *What funds can be used to purchase Depo, since we cannot use WHSF effective June 1, 2017?*

Any regular Family Planning funding can be used to purchase Depo. Some agencies identified Child Fatality Prevention Funds to use to purchase Depo. Funds earmarked for Depo should be identified as such in the Program Agreement.

Retention Schedules

1. *Are there plans to revise and update the current retention schedule?* We don't know, because it is done by State Archives. We have heard that they plan to add keeping RA's and Medicaid reports for 6 years to the next revision.

WIRM

1. *Are "View Only" roles available in WIRM?*
Not at this time.
2. *Can I get additional users added to my county?*
At this time, only three users are available for each county. For vacation coverage, write a memo saying that someone else used your login for that month. Then change your password.
3. *What if my county general ledger is not ready by the WIRM due date?*
Key in what you can and do amendments on the next month's report for the difference. Be careful to watch liquidation dates so you don't lose any available funding.
4. *I sometimes have Internet issues when keying WIRM where the remaining allocations change to zero or I get errors?*
Sometimes clicking the "Back" button will fix errors without having to sign off and back on.
5. *Why does it return to page 1 after printing?*
That is the way the system is designed. We will ask the Controllers' Office if this can be changed.
6. *Can the system be changed so that we only see activity lines for programs that we have signed Agreement Addenda?*
We will ask the Controllers' Office if this can be changed.
7. *Can we use the percentage of unwed non-Medicaid Family Planning patients to determine the percentage of Family Planning expenses to claim as TANF?*
Yes. Or you can have a separate column on the time equivalency to track the actual time worked providing TANF services.
8. *Are rent and utilities indirect costs?*
They may be, if your county pays these costs. If your agency pays the cost directly based on an allocation formula, then they might be considered actual expenses.
9. *Can WHSF be used for LARC insertion/removal or any other LARC related service?*
Yes.

Time Equivalency

1. *If our agency uses electronic time sheets, do we need to do time equivalency?*
Yes, so you can calculate actual program expenses.

2. *If TANF funds are drawn down for salary and fringe, do we need to have a TANF category on the time equivalency?*

It is best practice to have documenting evidence supporting the draw down of all state funds. If there is a separate category on the time equivalency (or if you use a patient percentage formula), then it is very clear that the funds were TANF.

3. *Can someone besides the employee change the time equivalency?*

The employee needs to initial any changes made on the time equivalency.