

Module 5: Table 4

SLIDE #1: Introduction

This module will cover table 4, charges collections and adjustments. Prisons, Indian Health Service, Section 638, and Immigration and Nationalization Service sites do not report this table.

SLIDE #2: Table 4

This is Table 4. It contains 2 main sections; the first having 2 columns, and the second section pertaining to self-pay adjustments having 1 column.

SLIDE #3: Charges, collections and adjustments

Column a reports on your charges, column b reports on the amount collected, and column c reports on adjustments specifically for your self-pay patients. We will cover each of these in detail.

SLIDE #4: Column a: Full charges

Full charges reported in column a refers to the gross charges for services provided to your patients based on your sites' fee schedule. Regardless of whether your patients are sliding fee discount patients, or full fee, insured or uninsured, the same fee would apply for the same services. Also be sure that you apply fees not just for visits but for direct services such as pharmaceutical, lab tests, and x-ray procedures, etc. Your charges are a measure of your service output, therefore they should be reflecting your gross charge prior to any discounts being applied.

SLIDE #5: Column b: Cash collected

Table 4 is a cash table, and Column b reports the amount collected in cash received during the calendar year. Because this is a cash table, it does not matter at what point during the year the service was provided. Cash received for a service that was provided at the end of the prior calendar year and paid during the current calendar year would be reflected, whereas a service provided at the end of this year that remains unpaid would not. Payments can come from a variety of sources: direct patient payments, including co-payments or payments for full services or partially discounted services, insurance company payments made to your site, and capitation payments made monthly on a per member per month basis, would all be considered direct reimbursement collected under Column b of this table. There are also indirect reimbursements that you may receive during the calendar year that would also be reflected in this column. These would include any cost-based adjustments that you receive under the federally qualified health center look alike or rural health clinic settlement if you are participating in either of those programs. Also many managed care plans provide for either withhold or incentive payments, including profit sharing that may be paid periodically throughout the year. Again all of these would be considered cash receipts and would be reported under Column b.

SLIDE #6: Fee-for-service and capitation definitions

Fee-for-service is essentially any arrangement for payment other than capitated. Fee-for-

service typically requires submitting a bill and receiving a payment in return for the level of services provided, even though the payment may not match or meet your charges.

Capitated plans are paid on a fixed, typically per member per month basis, and payments are received in advance and not tied to the level of service provided.

Carve outs are portions of capitated plans that have been designed to be paid on a fee for service basis. Examples of this might include pregnancy or might include certain diagnoses such as HIV. In these instances you would be paid a capitated rate for the basic care provided to those patients but some of the services that fall into these categories would be paid fee for service. If that's the case the capitated services and the capitated payments would be reported on the capitated line, whereas the carved out service would be brought down and reported on the fee for service line.

SLIDE #7: Payer classifications

There are five payer classifications on this table.

The payer categories here match the payer categories defined in table 2. Please refer to table 2 for a complete description of each payer category. Payer categories include Medicare, Medicaid, other public, private and self-pay. It is important when looking at these payer classes that any reclassifications of charges be reflected in both the charge and the payment columns.

This means that if a bill is submitted to a private insurance company, and that insurance company states that the patient has not met the deductible and the bill would be the patient's responsibility, both the charge for that service and the payment from the patient would both be moved down to the self-pay line. The same would true for Medicare in which the initial bill is submitted to the Medicare program; however, when a part B Medicare plan pays most of the charges both the charge and payment would be moved down to the private pay line which would include the Medicare part B plan. Lastly, partial payment for services should also be reclassified. For example, if a patient has a \$100 visit with a \$20 co-pay, the \$20 co-payment must be moved down to the self-pay line even if an insurance plan is paying the remainder of the charges.

SLIDE #8: Sliding fee adjustments

Beginning on line 15, table 4 collects information on discounts provided to your self-pay patients. Lines 15 and 16 pertain only to self-pay patients, not to your insured carriers. Line 15 discusses sliding fee adjustments. Sliding fee adjustments are discounts based on a policy set at your center in advance of the patient's service. The patients are typically notified that if they are unable to pay for care they may ask for such a discount. This is a requirement under your National Health Service Corps site agreement.

The discounts under sliding fee adjustment are based on the federal poverty guidelines and may be tiered based on a patient's income with greater discounts for lower levels of income. Sliding fee discounts differ from bad debt and retroactive charity care in that the discount is provided in advance of the service, rather than after the patient has been

billed. Hardship funds specifically set aside for these purposes can also be included as sliding fee adjustments.

SLIDE #9: Other self-pay adjustments

Line 16 refers to the “other self-pay adjustments” that are not included in the sliding fee discount.

Retroactive charitable write offs constitute instances where the patient was asked to pay for service but was ultimately unable to and the site takes the deduction as a charitable write off.

Alternately, bad debt would be reported on line 16 in the instance where a patient is billed potentially several times for services and is ultimately unable or does not pay for those services.

Bad debt may be written off against individual accounts based on a policy, or in the instance where an auditor recommends a write down to self-pay receivables, that write down can be taken as bad debt and reported on this line. It should be the actual amount written off during the calendar year.

SLIDE #10: Thank you

Thank you. If you are interested in learning more about the UDS reporting requirements and step-by-step instructions for completing the UDS tables, please visit the other modules available online. In addition, the UDS helpline is available to answer questions at 1-888-459-1080, or via e-mail at udshelp@nhscdata.net.