Dental Billing Policy

POLICY: It is the goal of Philadelphia FIGHT Family Dentistry (FIGHT Dental) to minimize any financial barriers to clinical care. As part of this effort, FIGHT has determined usual, customary, and reasonable charges for services that account for the customary fees in the geographic area as well as the actual cost of the services provided. Philadelphia FIGHT also employs a sliding fee discount schedule to minimize financial barriers for our target population.

PURPOSE: The purpose of this policy is to ensure that FIGHT Dental provides all services within the approved scope of project, while minimizing financial barriers and providing supports wherever possible.

I. SLIDING FEE PROGRAM

A. Eligibility for the Sliding Fee Program is based on income and family size only and no other factors, such as insurance status or population type, are considered when determining eligibility.

   i. Family size is defined as the number of patients living within a household.

   ii. Income is defined as money that a household receives on a weekly, monthly, or annual basis to be used for daily living expenses.

B. Patients applying for the Sliding Fee Program are required to provide proof of income documenting their combined household income. Verification of income may be submitted as a hard copy or electronically and may be obtained from one of the following:

   i. 1040 forms for the previous calendar year

   ii. copy of the previous year's W-2 form

   iii. letter from a current employer stating earnings

   iv. most recent pay stub(s)

   v. most recent unemployment check stub

   vi. social security/disability award letter for current calendar year or proof of another public assistance payment

C. Patient's income will be reassessed annually to determine eligibility for the Sliding Fee Program.

D. Patients are responsible for notifying FIGHT staff of any changes in income or household composition.

E. All patients are made aware of the Sliding Fee Program and availability of Payment Plans.

   i. The processes to inform patients of the Sliding Fee Program include:

      1. Signage at the clinic location

2. Information provided at the registration process and in advance of scheduling any appointments by the receptionists or Benefits Access Navigators.

3. Information included in FIGHT Dental brochures and marketing materials

4. Information on the Philadelphia FIGHT website.

ii. Information about the Sliding Fee Program will be available in both English and Spanish.

F. When evaluating Sliding Fee Program eligibility, and throughout the process of collecting patient information, patient privacy and confidentiality will be maintained in accordance with HIPAA and PA ACT 148 rules.

G. The Sliding Fee Program must be evaluated by the Board of Directors periodically, but a minimum of once per year, to assure that financial barriers to care are minimized.

i. The Board of Directors reviews the nominal fee on an annual basis to ensure that that fee is nominal from the perspective of the patient.

II. PAYMENT

A. If a patient is enrolled in an insurance plan that requires co-pays (inclusive of coinsurance and deductibles), payment will be expected on the date of service.

i. If a patient has been approved for the Sliding Fee Program, the patient will be charged the lesser of the Sliding Fee or the insurance co-pay (as allowed by contract).

B. If a procedure is denied by a patient's insurance plan, the patient has the option to pay for treatment in accordance with the Sliding Fee Scale, provided they meet the criteria to qualify for the Sliding Fee Program.

C. Elective dental treatment will be deferred until patient can provide Proof of Income.

i. Patients who present for elective dental treatment and are requesting to utilize the Sliding Fee Program for services but do not have Proof of Income available at the time of visit may pay full fees for the visit or elect to reschedule the appointment.

ii. Patients who cannot produce any of the Proof of Income documentation listed in section I.B can complete a self-attestation of income each time they present for a dental appointment.

D. Patients who decline to provide income documentation or refuse to engage with the Benefits Referral process where applicable, will be ineligible for participation in the Sliding Fee Program and will be responsible for 100% of treatment fees.

III. DENTAL SLIDING FEE SCALE

A. For **General Dental Services** provided to alleviate pain, resolve infections, and maintain good oral health, including diagnostic exams and imaging, prophylactic teeth cleaning, scaling and root planing (deep cleaning), and basic tooth fillings, the sliding fee scale is assessed based on the current Federal Poverty Guidelines (FPL) and a fee is associated with the visit based on the below specifications:

i. Patients whose household income and family size falls at or below 100% of the FPL will have a $5.00 financial responsibility for any FQHC general dentistry visits.
ii. Patients whose household income and family size falls over 100%, up to and including 125% FPL, will have a $10.00 charge for any FQHC general dentistry visits.
iii. Patients whose household income and family size falls over 125%, up to and including 150% FPL, will have a $15.00 charge for any FQHC general dentistry visits.
iv. Patients whose household income and family size falls over 150%, up to and including 175% FPL, will have a $20.00 charge for any FQHC general dentistry visits.
v. Patients whose household income and family size falls over 175%, up to and including 200% FPL, will have a $25.00 charge for any FQHC general dentistry visits.
vi. Patients whose household income and family size falls above 200% will not receive a discount on charges for services rendered on a particular date of service.

B. For **Specialty Dental Services** provided to restore function and esthetics, including complete and partial dentures, crowns, bridges, inlays/onlays, and nightguards, the Sliding Fee Program is assessed based on the current Federal Poverty Guidelines (FPL) and a fee is associated with the procedure based on the below specifications:
i. Patients whose household income and family size falls at or below 100% of the FPL will have a $40 fee for each visit involving Specialty Dental Services.
ii. Patients whose household income and family size falls over 100%, up to and including 125% FPL will have a $55 fee for each visit involving Specialty Dental Services.
iii. Patients whose household income and family size falls over 125%, up to and including 150% FPL will have a $70 fee for each visit involving Specialty Dental Services.
iv. Patients whose household income and family size falls over 150%, up to and including 175% FPL will have a $85 fee for each visit involving Specialty Dental Services.
v. Patients whose household income and family size falls over 175%, up to and including 200% FPL will have a $100 fee for each visit involving Specialty Dental Services.
vi. Patients whose household income and family size falls above 200% FPL will not receive a discount on charges for services rendered on a particular date of service.

IV. PRIOR AUTHORIZATION

A. Prior authorization may be required for certain procedures under certain insurance plans.
B. After a dental treatment plan has been established, prior authorization will be requested from the insurance company for any procedures requiring it.
C. Patients cannot be scheduled for the procedure until a prior authorization determination has been made.
i. Prior authorization can take up to 30 business days.
D. If the prior authorization is approved, front desk staff will call the patient to schedule their procedure.
E. If a prior authorization is denied, costs for services will be assessed based on financial responsibility guidelines outlined above; if patient is not eligible for Sliding Fee Program, patient will be responsible for 100% of treatment costs.
i. Patient will be required to sign a Noncovered Services consent form.
F. Patients may continue to utilize Urgent Care services while prior authorization is pending

V. PAYMENT PLANS

A. Once a treatment plan has been established, patients may request a financial consultation to discuss payment arrangements.
B. During the financial consultation, the dental staff will draft a Payment Plan based on the patient's current financial circumstances and how much they are comfortably able to pay towards the cost of treatment and at what frequency.

i. Patient must have updated insurance information and proof of income on file.
ii. If patient is uninsured and it has been more than a year since they met with a Benefits Access Navigator, they should be referred there first.
iii. All prior authorizations should be determined prior to the Financial Consultation.
iv. Patient must sign the Payment Plan agreement form, which will be scanned into the EMR.

C. FIGHT will defer elective dental treatment for any patients who have carried an outstanding balance for >90 days and have not made any payments toward that balance for >90 days.

VI. BENEFITS REFERRAL

A. If a patient does not have insurance and their income is at or below 150% of the FPL or if their income is higher but they or staff believe they have a qualifying health condition, they will be referred to a Benefits Access Navigator to determine if they are eligible for Medical Assistance, among other benefits.

B. With the patient's permission, a Benefits Access Navigator will contact them to identify any potential benefits, including Medical Assistance, for which they may qualify and will then assist in completing the application process.

C. If the Benefits Access Navigator determines that the patient is ineligible for Medical Assistance, costs for services will be assessed based on Sliding Fee Program eligibility; if patient is not eligible for Sliding Fee Program, they will be responsible for 100% of treatment costs.

D. If a patient refuses the Benefits Referral, becomes unresponsive to outreach attempts from a Benefits Access Navigator, or fails to comply with requests from a Benefits Access Navigator during the screening/application process, they will be responsible for 100% of treatment costs.
i. Patients may reengage with the Benefits Referral process at any time.

E. Patients may continue to utilize Urgent Care services during the Benefits Referral process or if they refuse to engage with referral process.