



COASTAL HEALTH & WELLNESS

GOVERNING BOARD

9850-A.106 Boardroom Emmett F. Lowry Expressway, Texas City

SPECIAL MEETING AGENDA Wednesday, April 30, 2025 5:00 PM

CONSENT AGENDA: ALL ITEMS MARKED WITH A SINGLE ASTERICK (*) ARE PART OF THE CONSENT AGENDA AND REQUIRE NO DELIBERATION BY THE GOVERNING BOARD. ANY BOARD MEMBER MAY REMOVE AN ITEM FROM THIS AGENDA TO BE CONSIDERED SEPARATELY.

PROCEED TO BOTTOM OF THIS DOCUMENT FOR APPEARANCE & EXECUTIVE SESSION GUIDELINES

In accordance with the provisions of the Americans with Disabilities Act (ADA), persons in need of a special accommodation in order to participate in this proceeding should, within two (2) days prior to the proceeding, request necessary accommodations by contacting CHW's Executive Assistant at 409-949-3406, or via email at trollins@gchd.org

ANY MEMBERS NEEDING TO BE REACHED DURING THE MEETING MAY BE CONTACTED AT 409-938-2288

SPECIAL MEETING

**Meeting Called to Order
Pledge of Allegiance**

- *Item #1**ACTION**..... Comments from the Public
- *Item #2**ACTION**..... Consider for Approval Minutes from March 27, 2025 Governing Board Meeting
- *Item #3**ACTION**..... Consider for Approval Minutes from April 10, 2025 Governing Board QA Committee Meeting
- *Item #4**ACTION**..... Consider for Approval Coastal Health & Wellness 2025-2026 Risk Management Training Plan
- *Item #5**ACTION**..... Consider for Approval Coastal Health & Wellness Quarterly Compliance Report for the Period Ending 3/31/2025
- *Item #6**ACTION**..... Consider for Approval Quarterly Investment Report for the Period Ending 3/31/2025
- Item #7**ACTION**..... Consider for Approval Financial Report Submitted by Ruth Cable
a) March 2025
- Item #8**ACTION**..... Consider for Approval Revenue Cycle Management Policies and Procedures Submitted by Lisa Garceau
- Item #9**ACTION**..... Consider for Approval Coastal Health & Wellness 2025 Medical Fee Schedule Submitted by Lisa Garceau
- Item #10**ACTION**..... Consider for Approval Coastal Health & Wellness 2025 Dental Fee Schedule Submitted by Lisa Garceau
- Item #11**ACTION**..... Consider for Approval Coastal Health & Wellness 2025 Dental Contract Fee Schedule Submitted by Lisa Garceau

Item #12**ACTION**.....Consider for Approval Coastal Health & Wellness 2025 Dental Contract Discount Eligibility Fee Schedule Submitted by Lisa Garceau

Item #13.....Comments from Board Members

Adjournment

Next Regular Scheduled Meeting: May 22, 2025

Appearances before the Coastal Health & Wellness Governing Board

A speaker whose subject matter as submitted relates to an identifiable item of business on this agenda will be requested by the presiding officer to come to the podium where they will be limited to three minutes (3). A speaker whose subject matter as submitted does not relate to an identifiable item of business on this agenda will be limited to three minutes (3) and will be allowed to speak before the meeting is adjourned. Please arrive prior to the meeting and sign in with Galveston County Health District staff.

Executive Sessions

When listed, an Executive Session may be held by the Governing Board in accordance with the Texas Open Meetings Act. An Executive Session is authorized under the Open Meetings Act pursuant to one or more the following exceptions: Tex. Gov't Code §§ 551.071 (consultation with attorney), 551.072 (deliberation regarding real property), 551.073 (deliberation regarding a prospective gift or donation), 551.074 (personnel matters), 551.0745 (personnel matters affecting Coastal Health & Wellness advisory body), 551.076 (deliberation regarding security devices or security audits), and/or 551.087 (deliberations regarding economic development negotiations). The Presiding Officer of the Governing Board shall announce the basis for the Executive Session prior to recessing into Executive Session. The Governing Board may only enter into Executive Session if such action is specifically noted on the posted agenda.

**Coastal Health & Wellness
Governing Board
March 27, 2025**

Board Members:

Donnie VanAckeren
Courtnei Tello, DDS
Rev. Jones
Sharon Hall
Sergio Cruz
Flecia Charles
Victoria Dougharty

Staff:

Philip Keiser, MD, Executive Director	Tiffany Carlson, RN, Nursing Director
Lane Baker, MHA, Chief Operating Officer	Tomiko Fisher, Grant Manager
Chris Garcia, MD, Medical Director	Christina Bates
Hanna Lindskog, DDS, Dental Director	Lisa Garceau
Della Brown, RN, GCHD Chief Operating Officer	Terry Chapa
Ruth Cable, Chief Financial Officer	Tikeshia Thompson-Rollins
Liz Lentz, Human Resources Director	
Ashley Sciba, RN, Chief Nursing Officer	

Excused Absences: Elizabeth Williams, Kevin Avery, Cynthia Darby & Kendall Campbell, MD

Items#1 Comments from the Public

There were no comments from the public

Items#2-5 Consent Agenda

A motion was made by Courtnei Tello, DDS, to approve consent agenda items two through five and defer item eight. Sharon Hall seconded the motion, and the Board unanimously approved the consent agenda.

Item#6 Consider for Approval 2025 Dental Fee Schedule Submitted by Lisa Garceau

Lisa Garceau, Payor Contracting & Credentialing Manager, asked the Board to consider for approval 2025 Dental Fee Schedule. A discussion was held regarding moving the fees to the 80th percentile for the area. A motion to accept the dental fee schedule as presented was made by Courtnei Tello, DDS. Sharon Hall seconded the motion, and the Board unanimously approved.

Item#7 Consider for Approval 2025 Medical Fee Schedule Submitted by Lisa Garceau

Lisa Garceau, Payor Contracting & Credentialing Manager, asked the Board to consider for approval. A motion to accept the medical fee schedule as presented was made by Sharon Hall. Courtnei Tello, DDS seconded the motion, and the Board unanimously approved.

Item#8 Consider for Approval Coastal Health & Wellness Discount Eligibility (Sliding Fee) Schedule 2025/2026 Submitted by Lisa Garceau

Lisa Garceau, Payor Contracting & Credentialing Manager, asked the Board to consider for approval Coastal Health & Wellness Discount Eligibility (Sliding Fee) Schedule 2025-2026. Donnie VanAckeren, Board Chair, informed the Board that the CHW Discount Eligibility Sliding Fee Schedule was previously approved at the February 6th Governing Board meeting and asked that a motion be made to keep the discount eligibility sliding fee schedule as presented at the February 6th meeting expiring February 6, 2026. A motion to accept the discount eligibility sliding fee schedule as presented on February 6, 2025 was made by Courtnei Tello, DDS. Sharon Hall seconded the motion, and the Board unanimously approved.

Item#9 Consider for Approval Financial Report Submitted by Ruth Cable

a) February 2025

Ruth Cable, Chief Financial Officer, presented the February 2025 financial report. A motion to accept the February 2025 finance report as presented was made by Sergio Cruz. Sharon Hall seconded the motion, and the Board unanimously approved.

Item#10 Coastal Health & Wellness Updates

- a) Organizational Updates Submitted by Executive Director
- b) Dental Updates Submitted by Dental Director
- c) Medical Updates Submitted by Medical Director
- d) Human Resources Updates Submitted by Human Resources Manager

Organizational Updates:

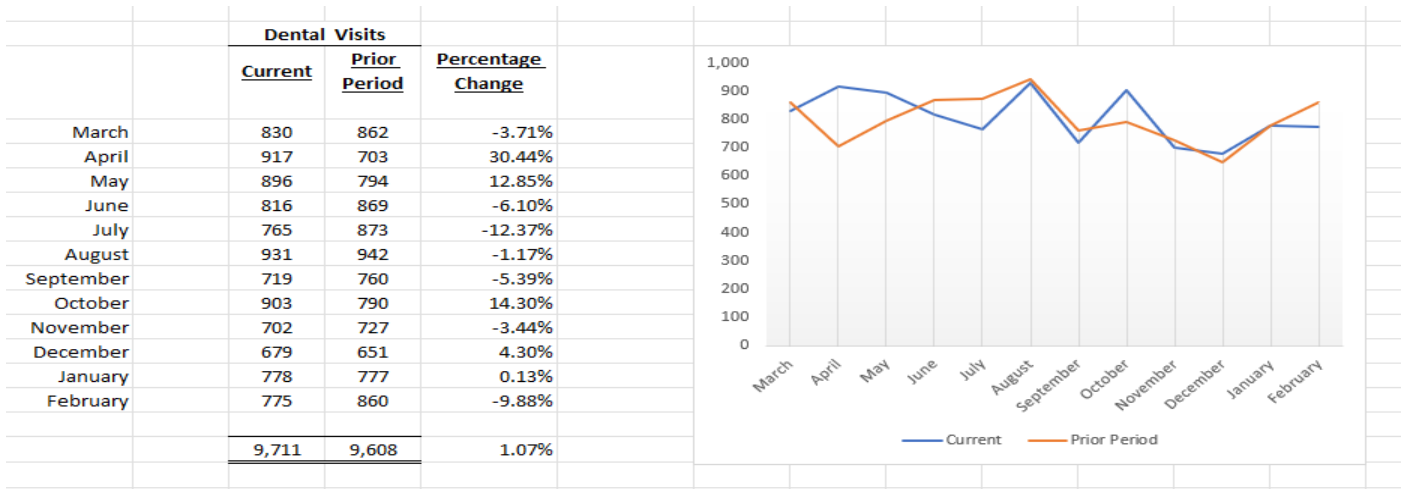
Philip Keiser, MD, presented organizational updates to the Governing Board on the Measles Outbreak.

Operational Updates:

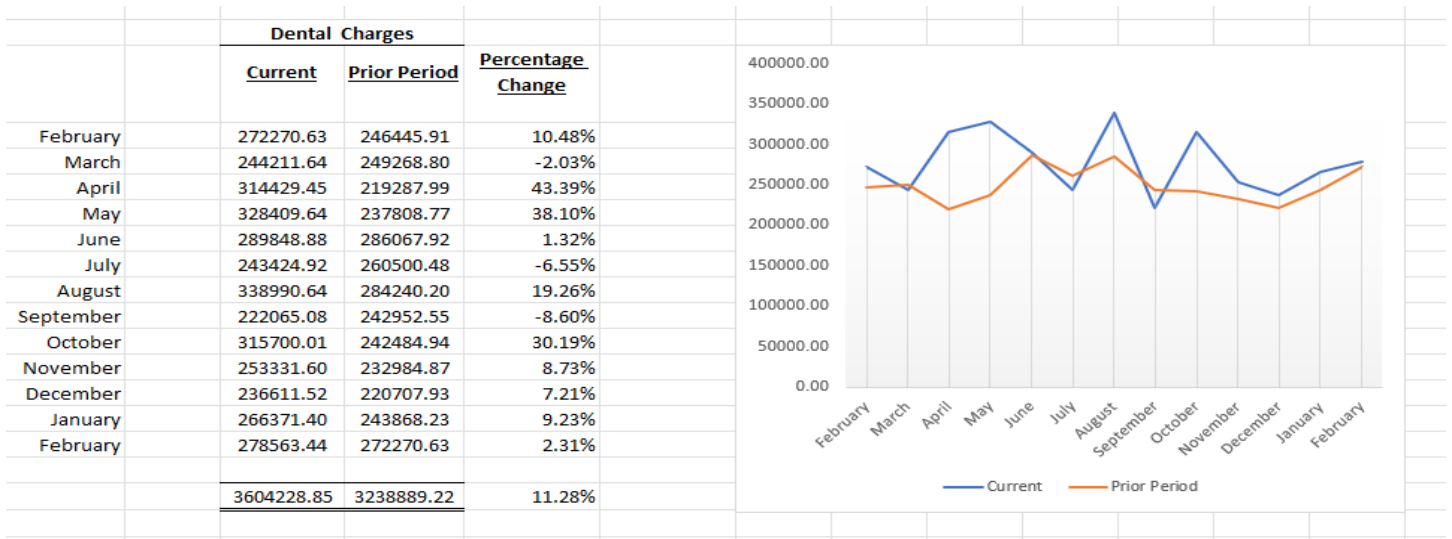
Lane Baker, Chief Operating Officer, presented Operational Updates to the Governing Board.

Dental Updates:

- Visit Numbers – Based on “FQHC Qual Enc” in NextGen
 - We continue to see walk in patients in pain as we can fit them into our schedule.
 - We continue to release comprehensive exams on the 15th of every month.
 - For February 2025, the Dental Clinic had a decrease of 9.88% in qualifying encounters compared to February 2024. We had two dentists that were out for one week due to expiring vacation grace time
 - The Dental Clinic had an increase of 1.07% in qualifying encounters when comparing March 1, 2024 – February 28, 2025, with March 1, 2023 – February 29, 2024.



- Dental Charges
 - For February 2025, the Dental Clinic had an increase in charges of 2.31% compared to February 2024.
 - The Dental Clinic had an increase of 11.28% in charges when comparing March 1, 2024 – February 28, 2025, with March 1, 2023 – February 29, 2024.



- Current projects, plans, department overview for dental
 - Dr. Lindskog continues to serve on the COM Hygiene School Advisory Board

- Exploring opportunities for rotations at CHW for dental hygiene students
- UT Health School of Dentistry (Houston)
 - Exploring opportunities for rotations at CHW for dental students and residents
- Head Start
 - Francine is working with the school to proactively complete packets for the 2025-2026 school year during their registration and Back to School events

Medical Updates:

School Based Clinic:	January	February
Students:	5	3
Staff:	0	1
Telehealth:	38	36
Total :	43	40
Telehealth/Doxyme:	January visits	February visits
	229	160
CHW Clinic Visits:	January visits	February visits
Kept:	2127	2093
No Shows:	686	664
No show rate:	24.4%	24.1%
Retinal scans	39	40
Total charges:	\$577,725.20	\$573,375.73

Clinic Updates:

We continue to partner with UTMB and St Vincent on study to improve diabetic control. We continue with our weekly meetings, now focusing on getting final testing for the patients. This year’s program is winding down. UTMB submitting grant applications for a continuation of the program. They are anticipating initial results of study sometime this summer. We are developing an internal orthopedic focused clinic. One of our current providers has extensive experience in orthopedics. This may include injections of knees and shoulders IF appropriate. We are in preliminary discussions with the Internal Medicine and Family Medicine departments from UTMB about the possibility of having their residents staffing evening and Saturday clinics

Human Resources Updates:

Liz Lentz, Human Recourses Director, presented Human Recourse Updates to the Board.

- Active EE Count (95)
- Hired EE’s for Month -February (1)
- Termed EE’s for Month - February (1)
- Active EE Count for Prior Year - February 2024 (126)
- Hired EE’s for Month - February 2024 (3)
- Termed EE’s for Month - February 2024 (3)
- Open Positions (0)

Turnover Rate Calculation

Month	Number of Separated Employees	Average Number of Employees	Monthly Turnover Rates (Percentage)	Quarterly Turnover Rates	Annual Turnover Rate
January	24	95	25.3%	26.3%	26.3%
February	1	95	1.1%		
March	0	97	0.0%		
April	0	97	0.0%	0.0%	
May	0	97	0.0%		
June	0	97	0.0%		
July	0	97	0.0%	0.0%	
August	0	97	0.0%		
September	0	97	0.0%		
October	0	97	0.0%	0.0%	
November	0	97	0.0%		
December	0	97	0.0%		

As of 03/20/25

2025 New Hires & Upcoming

Hire Date	Department	Job Title	Position #
01/23/25	CHW RCM	RCM Billing Specialist	CHW-RCM-003
02/03/25	CHW Administration	CHW Chief Operating Officer	CHW-ADM-001

Item #11 Comments from Board Members

None

The meeting was adjourned at 1:15p.m.

Chair

Secretary/Treasurer

Date

Date

[Back to Agenda](#)

**Coastal Health & Wellness Governing Board
Quality Assurance Committee
Meeting
April 10, 2025**

BOARD QA COMMITTEE MEMBERS:

Sharon Hall-Community Member

EMPLOYEES PRESENT:

Lane Baker (Chief Operating Officer), Dr. Lindslog (Dental Director), Dr. Garcia (Medical Director), Jason Borillo (Director of Innovation and Clinical Quality), Liz Lentz (Human Resources Director), Laura Norman (Emergency Management Coordinator), Tiffany Carlson (Nursing Director), Ashley Sciba (Chief Nursing Officer), Virginia Lyle (Galveston Clinic Manager), Wendy Jones (Compliance and Risk Management Officer) and Judie Olivares (Human Resources Manager)

(Minutes recorded by Tikeshia Thompson-Rollins)

ITEM	ACTION
<p>Patient Access / Satisfaction Reports</p> <ul style="list-style-type: none"> ➤ Quarterly Access to Care Report Submitted by Luz Amaro ➤ Quarterly Patient Satisfaction Report Submitted by Luz Amaro ➤ Call Quality Performance Submitted by Luz Amaro 	<p><u>Quarterly Access to Care Report</u></p> <ul style="list-style-type: none"> • Jason Borillo reviewed the access to care report for the 1st quarter (January, February & March) in Luz Amaro’s absence. The cumulative no-show rate is at 26.1%. <p><u>Quarterly Patient Satisfaction Report</u></p> <ul style="list-style-type: none"> • The goal was previously set at 90% with the categories below. <ul style="list-style-type: none"> ➤ Excellent ➤ Very Good ➤ Good • Overall Satisfaction: 94.9% for the 1st quarter. <p><u>Call Quality Performance</u></p> <ul style="list-style-type: none"> ➤ Jason will work with Luz to get graphs of quarterly comparisons added to the report and bring back to the July committee meeting.
<p>Clinical Measures</p> <ul style="list-style-type: none"> ➤ Quarterly Report on UDS Medical Measures in Comparison to Goals Submitted by Jason Borillo 	<p><u>Clinical Measures</u></p> <ul style="list-style-type: none"> • Report reviewed; No Action

<p>Quality Assurance/Risk/Management/ Emergency Management Reports</p> <ul style="list-style-type: none"> ➤ Quarterly Risk Management Report Submitted by Wendy Jones ➤ Dental Quarterly Summary Submitted by Dr. Lindskog ➤ Quarterly Emergency Management Report Submitted by Laura Norman 	<p><u>Quarterly Risk Management Report</u></p> <ul style="list-style-type: none"> • Wendy will change (ensure incidents and adverse events are promptly reported) category to yellow. • Wendy will modify Patient Satisfaction Survey goal and bring results back to the next committee meeting. <p><u>Dental Quarterly Summary</u></p> <ul style="list-style-type: none"> • Report reviewed, No Action. <p><u>Quarterly Emergency Management Report</u></p> <ul style="list-style-type: none"> • Laura Norman reviewed the Emergency Management Report for the 1st quarter and gave updates on training and ongoing/future projects.
--	---

Next Meeting: July 10, 2025

[Back to Agenda](#)



Coastal Health & Wellness

2025 Risk Management Training Plan

Revised & Approved: April 2025

Article I Risk Management Training Program Goals

Risk Management is the responsibility of all Coastal Health & Wellness (“CHW”) employees, including providers, clinicians, managers, volunteers, and staff. Risk management spans the entire operation and most functional areas, and all employees should be trained on risk management functions and responsibilities. CHW’s Risk Management Training Program’s goals and objectives are to create a culture of safety by:

1. Promoting safe and effective patient care practices;
2. Minimizing errors, events, and system breakdowns;
3. Minimizing effects of adverse events when they occur;
4. Minimizing losses to CHW by being proactive and attentive;
5. Maintaining a safe working environment;
6. Facilitating compliance with regulatory, legal, and accrediting agencies;
7. Protecting CHW’s financial resources; and
8. Protecting human and intangible resources.

Article II Process for Selection of Training Requirements

1. Using trend data and other risk management data (e.g., claims data, patient complaints, incident reports, adverse events, services provided and inherent nature/risk of such services), the areas/activities of highest risk for CHW patient safety and ensuring consistency with CHW’s identified scope of project(s).
2. Training courses are then selected to mitigate or minimize the areas identified as highest risk.

Article III Training Courses

- All staff will be trained on risk management topics applicable to their scope of work upon hire and thereafter on an annual basis. This includes providers, clinicians, managers, volunteers, and support staff.
- CHW has identified required courses for all staff and specialized training to mitigate or minimize risk of injury to patients and potential for liability to CHW, as set forth in Paragraphs 3 and 4 of this Article.
- **Required Courses for All Staff.** All staff will be required to complete risk management training on the following in accordance with the schedule as outlined in CHW’s Risk Management Training Log (see Risk Management Training Log):

COURSE NAME (TENTATIVE TRAINING SCHEDULE**)

Phase 1 – January - April

- Anti-Fraud Training
- Emergency Operations Plan
- Harassment Training
- Child, Elderly and Domestic Abuse Reporting Training

Phase 2 – May - August

- Cultural and Linguistic Training
- Fire Safety Training
- Pain and Pain Management
- Creating a Culture of Safety
- Obstetrics: Safe, Equitable Care for all Women

Phase 3: September - December

- Infection Control: Hand Hygiene
- Infection Control: Bloodborne Pathogen Exposure
- Safety Management Plans
- Hazardous Communication Training
- Identifying and Reporting Human Trafficking

- HIPAA and Patient Confidentiality
- **Specialized Courses for Select Staff.** In addition to the required courses outlined above, staff in the following professions/fields will also be required to attend and complete specialized risk management courses applicable to these professions/fields, in accordance with the schedule/due dates outlined in CHW’s Risk Management Training Log (see, Risk Management Training Log):
 - i. All practitioners must complete their continuing medical education requirements or other applicable licensure requirements to maintain licensure, registration or certification.
 - ii. **Obstetrics/Gynecology:** Prenatal and postpartum care providers are required to complete risk management training specific to this type of care. **UTMB Residents provide OB services (prenatal and postpartum care only).**
 - iii. Providers and Clinicians: Pain and pain management education on assessment and management of pain. All onboarding (new staff) and annual training required.
 - iv. **Dental Instrument Sterilization Training** for select staff, as applicable. *CHW exclusively uses disposable instruments for all medical and laboratory procedures, therefore only members of the dental staff are required to undergo instrument sterilization training.*
 - v. CHW requires specific risk management trainings for groups of providers that perform various services which may lead to potential risk including:
 1. Behavioral Health
 2. Dental
 3. Maternal Health Care
 4. Substance Abuse Disorder
 - vi. Staff that handle biohazardous materials must complete the Department of Transportation (DOT), Biohazardous Medical Waste and Disposal training within (90) days of hire and every three years thereafter.
 - vii. Providers will be educated on reporting potential malpractice claims that could invoke litigious action, and the Anti-Kickback and Stark Laws.
- **Other Courses/Training.** The Risk Manager may identify and require additional courses/training for some or all staff, as appropriate, to address any incident, identified trend, near miss, patient complaint, or any other circumstance.

Article IV Tracking Training Attendance and Completion

1. Tracking Methods

- a. Staff must complete all required applicable risk management training upon hire and on an annual basis thereafter.
- b. Attendance and/or completion of training courses will be tracked in a manner appropriate to the method by which the course was conducted (e.g., in-service sign-in log for in-person courses; certificates of completion for individual online courses, attestation of review and completion for other courses).
- c. Staff who are unable to attend in-service sessions during which a required training is provided must make-up the training by attending the next New Hire Orientation session, where the training(s) will be offered, or will be required to complete the training in the online training upon return to work.

2. Performance Reviews/Credentialing and Privileging

- a. Compliance with training requirements will be documented in staff personnel records and considered during performance reviews and/or credentialing and privilege determinations.

3. Non-Compliance with Training Requirements

- a. The Risk Manager in conjunction with Human Resources will monitor staff compliance with training requirements. Failure to complete the training may result in staff's referral to Human Resources for disciplinary action, up to and including termination.

4. Appropriate Sources of Training/Mode of Delivery

- a. Training is facilitated during employee in-service sessions, which are held from 8:00 am-12:00 pm on the second Wednesday of every month.
- b. Training may also be conducted either in person, online, individually or in a group setting utilizing courses developed by CHW or through outside sources (e.g., ECRI Institute; Stericycle, MedTrainer;).

[Back to Agenda](#)

Coastal Health & Wellness Governing Board
Q.1 (January – April)
FY2025 Compliance Report

Internal Audits		
AUDITOR & DATE CONDUCTED	TYPE OF AUDIT & FINDINGS	ACTION TAKEN
Nursing Supervisor Jan, Feb, March	Abnormal Pap Audited for: <ul style="list-style-type: none"> Will report during Q2 Compliance Report 	
EHR System Administrator	Dental Department Audited for secure access to EHR System: <ul style="list-style-type: none"> Operatories were audited for HIPAA Security Risks. Introduced use of a password management system to help providers and staff operate with reduced risk of erroneous access to EHR system. 	<ul style="list-style-type: none"> It issued KnowB4 Trainings to staff in how to use password management system: KeePass
AUDITOR & DATE CONDUCTED	TYPE OF AUDIT & FINDINGS	ACTION TAKEN
Nursing Director/Designee	Title V Well Child Audit -Screening: <ul style="list-style-type: none"> None this quarter (Audits conducted Bi-annual) 	
Title V Dental Child Screenings	Title V Audit of Child Dental Audit <ul style="list-style-type: none"> None this quarter 	
External Audit(s)		
Feb. 13, 2025 Texas DSHS Immunization Program Vaccines for Children Program (VFC)	VFC Compliance Visit – Audited all components of vaccine administration from billing, receiving, storing, administration of vaccines. <i>No compliance issues were identified</i> <ul style="list-style-type: none"> I.E., Eligibility, Billing, Administration Fees, Dose documentation, records retention, vaccine management plan, storage & handling, temperature monitoring, certifications of calibration testing, documentations: dosage, temperature, preparation of vaccines, emergency transport of vaccine, etc. 	
Feb. 20, 2025	ASN Compliance Audit: Audited all components of vaccine administration from receiving, storing, administration of vaccines, to billing. <i>No compliance issues were identified</i>	

Submitted by: Wendy Jones, Compliance Officer
 Coastal Health & Wellness Governing Board – April 2025

Coastal Health & Wellness Governing Board
Q.1 (January – April)
FY2025 Compliance Report

Texas DSHS Immunization Program Adult Safety Net (ASN) Program	<ul style="list-style-type: none"> I.E., Eligibility, Billing, Administration Fees, Dose documentation, records retention, vaccine management plan, storage & handling, temperature monitoring, certifications of calibration testing, documentations: dosage, temperature, preparation of vaccines, emergency transport of vaccine, etc. 	
HIPAA Breach Reports		
DEPARTMENT – DATE OCCURRED	SUMMARY	ACTION TAKEN
	None	
Warning and Termination Letters		
REASON	TYPE OF LETTER	
<ul style="list-style-type: none"> Patient non-compliance with Rights & Responsibilities as designated in the Rights and Responsibilities Agreement with CHW 	<ul style="list-style-type: none"> Warning Letter 	

Incidents involving quality of care issues, in accordance with Section 161 et seq., Health and Safety Code, are reviewed such that proceedings and records of the quality program and committee reviews are privileged and confidential.

[Back to Agenda](#)

**Coastal Health & Wellness
Investment Report
For the period ending March 31, 2025**

Coastal Health & Wellness	Money Market Account		
	January	February	March
Beginning Balance	6,918	6,929	6,940
Deposits	-	-	-
Withdrawals	-	-	-
Interest Earned	12	11	12
Ending Balance	\$6,929	\$6,940	\$6,952
Current Annual Yield	2.020%	2.020%	2.020%
Previous Quarter Yield (10/2024 - 12/2024)	2.010%	2.010%	2.010%

Tex Pool Investments		
January	February	March
7,362	7,390	7,414
-	-	-
-	-	-
27	25	27
7,389	7,415	7,441
4.391%	4.365%	4.349%
4.862%	4.668%	4.477%

Summary - FY25	Interest Earned	Avg Balance	Yield
Q1 = Apr 1, 2024 to Jun 30, 2024	26,496	2,085,206	1.02%
Q2 = Jul 1, 2024 to Sep 30, 2024	6,497	487,430	0.92%
Q3 = Oct 1, 2024 to Dec 31, 2024	2,752	232,470	0.85%
Q4 = Jan 1, 2025 to Mar 31, 2025	114	14,318	0.00%
YTD Totals	\$35,859	\$2,819,423	2.79%

Coastal Health & Wellness	Q1	Q2	Q3	Q4	YTD Comparison
Interest Yield Year to Year Comparison	Apr 1-Jun 30	Jul 1-Sep 30	Oct 1-Dec 31	Jan 1-Mar 31	Total as of Mar 31
FY2022	0.13%	0.32%	0.00%	0.00%	0.45%
FY2023	0.87%	1.04%	0.00%	0.00%	1.91%
FY2024	0.83%	0.87%	0.85%	0.00%	1.70%
FY2025 (Current year)	1.02%	0.92%	0.85%	0.00%	1.94%

[Back to Agenda](#)

COASTAL HEALTH & WELLNESS

Governing Board



FINANCIAL SUMMARY

For the Period Ending

March 31, 2025

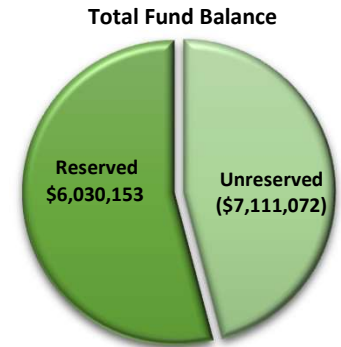
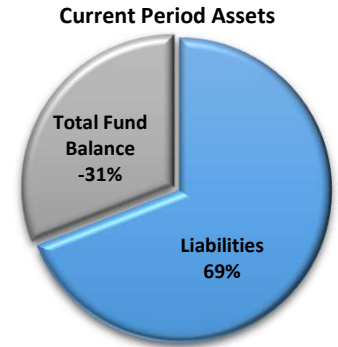
GCHD Board Room | 9850-A Emmett F. Lowry Expy. | Texas City, TX 77591

April 15, 2025

CHW - BALANCE SHEET

as of March 31, 2025

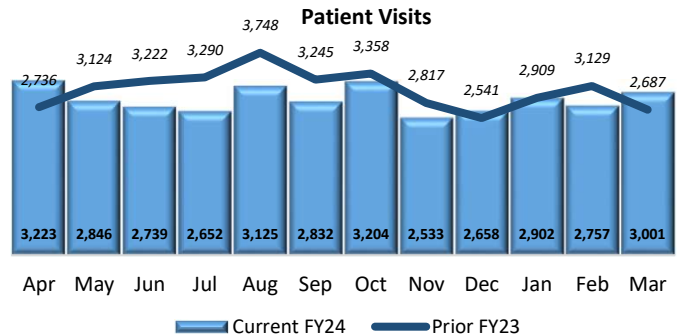
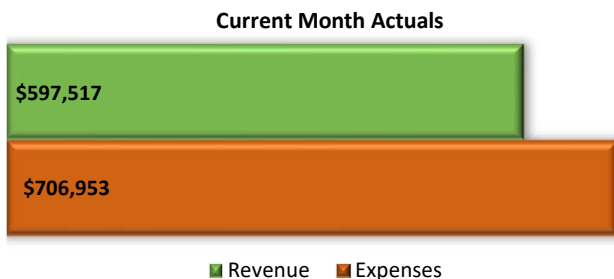
	Current Month Mar-25	Prior Month Feb-25	Increase (Decrease)
ASSETS			
Cash & Cash Equivalents	\$596,363	\$420,672	\$175,691
Accounts Receivable	4,336,466	4,021,375	315,090
Allowance For Bad Debt	(575,271)	(551,087)	(24,184)
Pre-Paid Expenses	574,528	554,604	19,923
Due To / From	(3,596,067)	(3,140,775)	(455,292)
Total Assets	\$ 1,336,018	\$ 1,304,790	\$ 31,228
LIABILITIES			
Accounts Payable	\$981,503	\$855,910	\$125,593
Accrued Expenses	1,386,909	1,372,737	14,173
Deferred Revenues	48,525	48,525	0
Total Liabilities	\$2,416,938	\$ 2,277,172	\$ 139,765
FUND BALANCE			
Fund Balance	\$7,694,079	\$7,694,079	\$0
Current Change	(8,774,998)	(8,666,461)	(109,437)
Total Fund Balance	\$ (1,080,919)	\$ (972,382)	\$ (109,437)
TOTAL LIABILITIES & FUND BALANCE	\$ 1,336,018	\$ 1,304,790	\$ 31,228



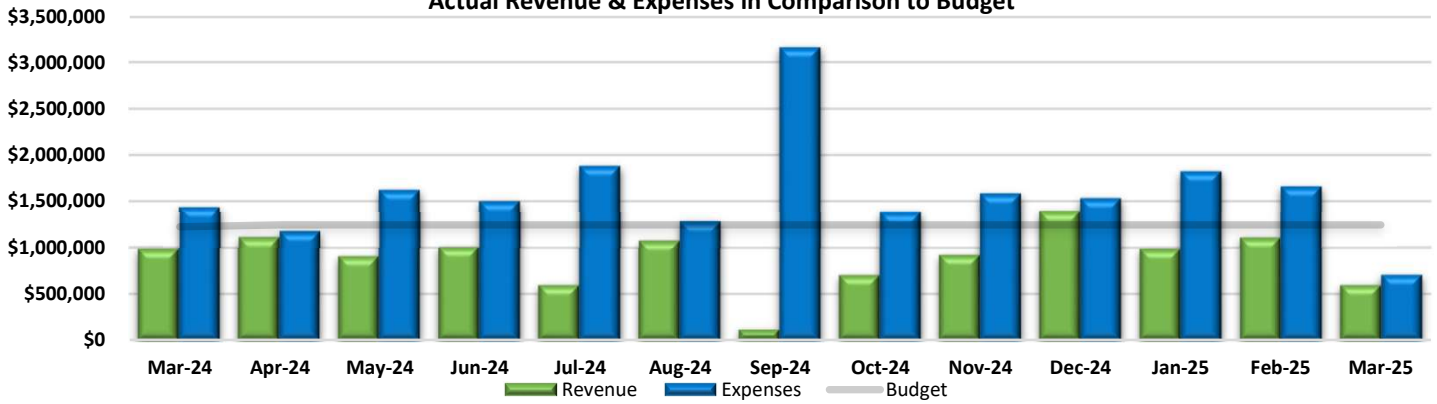
CHW - REVENUE & EXPENSES

as of March 31, 2025

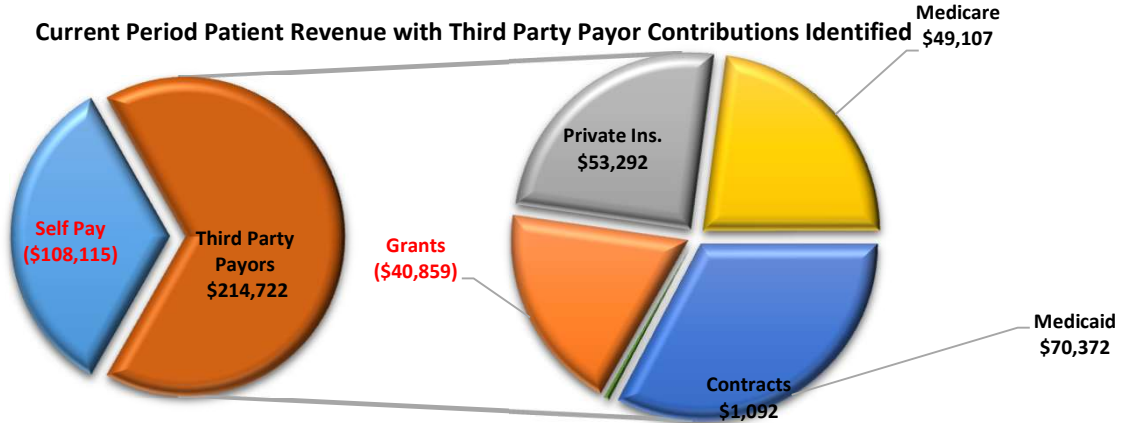
	MTD Actual Mar-25	MTD Budget Mar-25	MTD Budget Variance	YTD Actual thru Mar-25	YTD Budget thru Mar-25	YTD Budget Variance
REVENUE						
County Revenue	\$228,381	\$244,556	(\$16,175)	\$2,740,567	\$2,934,667	(\$194,100)
HHS Grant Revenue	218,863	269,783	(50,920)	3,005,842	3,237,400	(231,558)
Patient Revenue	130,928	701,772	(570,844)	4,434,905	8,421,263	(3,986,358)
Other Revenue	19,345	29,500	(10,155)	375,267	354,000	21,267
Total Revenue	\$597,517	\$1,245,611	(\$648,094)	\$10,556,581	\$14,947,330	(\$4,390,749)
EXPENSES						
Personnel	\$684,991	\$1,017,304	\$332,313	\$11,208,849	\$12,207,643	\$998,794
Contractual	217,702	99,740	(117,962)	2,752,299	1,196,874	(1,555,425)
Supplies	176,390	140,969	(35,422)	1,806,543	1,691,624	(114,919)
Travel	1,383	2,017	633	17,513	24,200	6,687
Equipment/Capital	3,014	0	(3,014)	758,339	0	(758,339)
Bad Debt Expense	(416,026)	57,536	473,562	1,672,714	690,432	(982,282)
Other	39,499	141,845	102,346	1,126,782	1,702,136	575,354
Total Expenses	\$706,953	\$1,459,409	\$752,456	\$19,343,041	\$17,512,909	(\$1,830,132)
CHANGE IN NET ASSETS	(\$109,436)	(\$213,798)	\$104,362	(\$8,786,460)	(\$2,565,579)	(\$6,220,881)



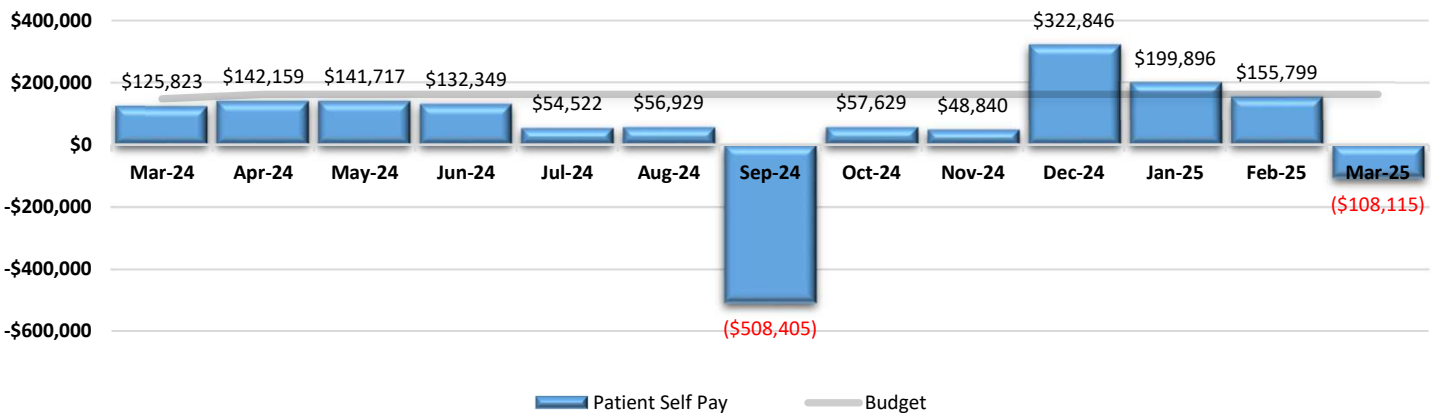
Actual Revenue & Expenses in Comparison to Budget



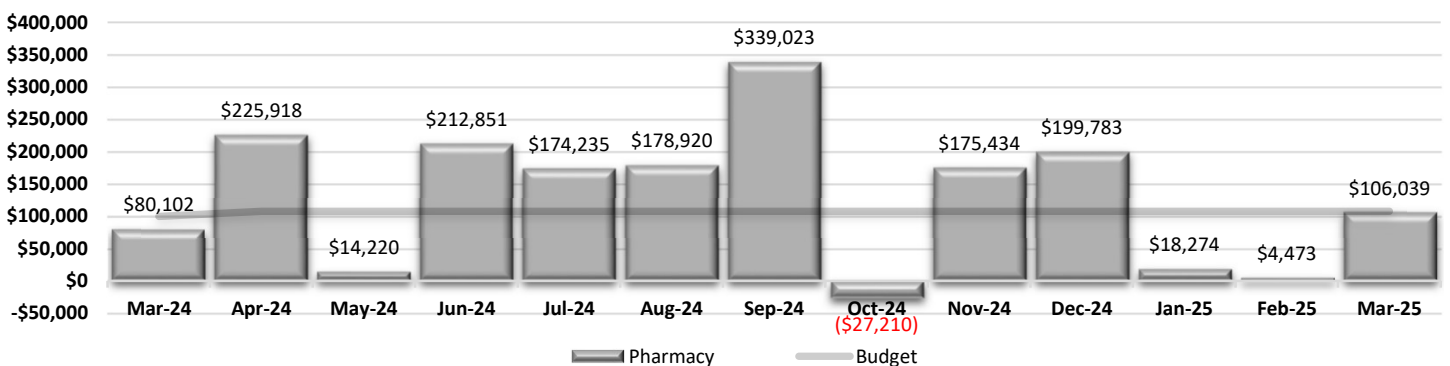
Current Period Patient Revenue with Third Party Payor Contributions Identified



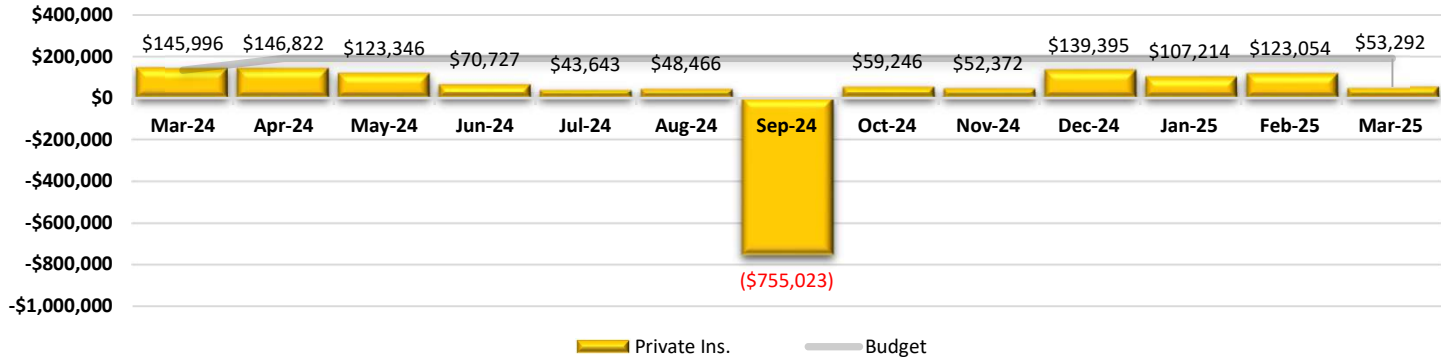
Patient Self Pay Revenue with Budget Line Comparison



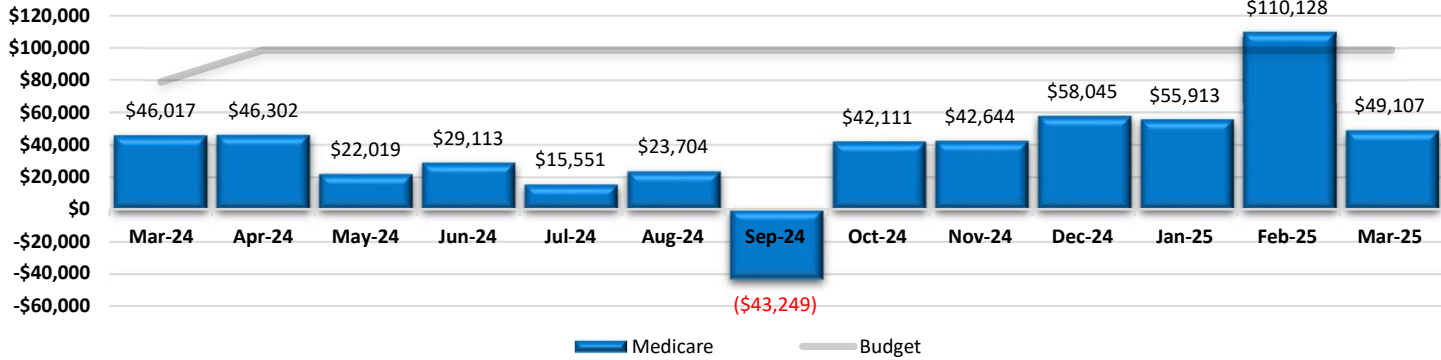
Pharmacy Revenue with Budget Line Comparison



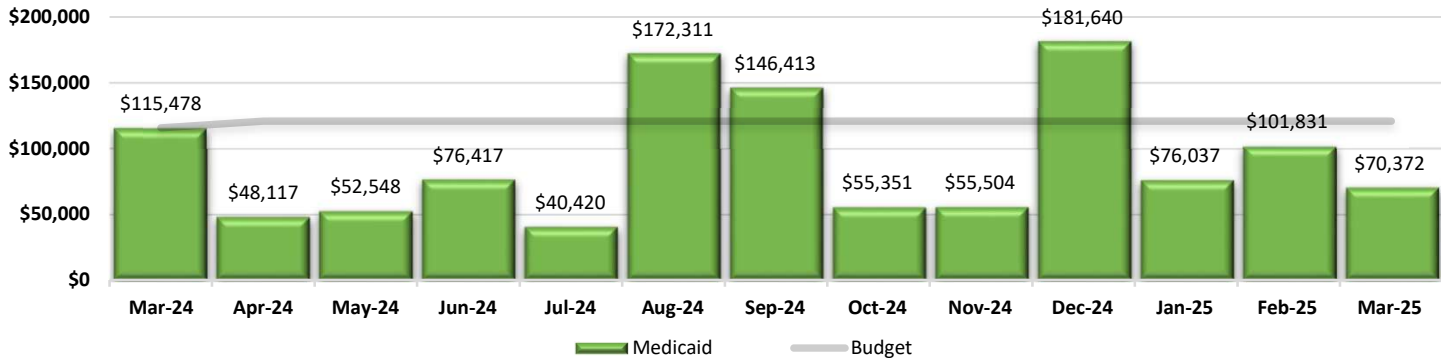
Private Insurance Revenue with Budget Line Comparison



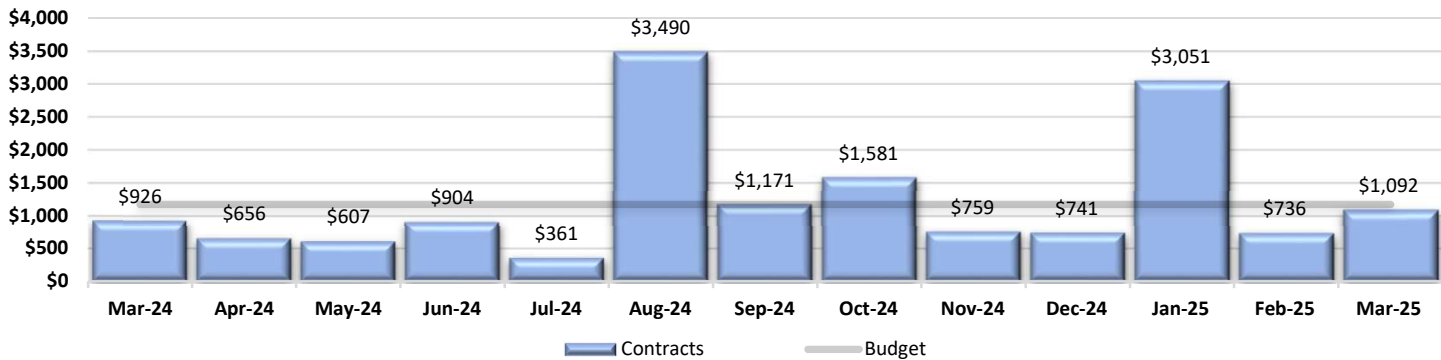
Medicare Revenue with Budget Line Comparison



Medicaid Revenue with Budget Line Comparison



Contract Revenue with Budget Line Comparison





Revenue Cycle Management Policies and Procedures

Updated June 24, 2024

TABLE OF CONTENTS

- Table of Contents.....2**
- I. Coastal health & wellness Mission, Vision, & Values2**
 - Our Mission.....2*
 - Our Vision2*
 - Our Values2*
- II. Insurance Verification Policy & Procedure.....3**
- III. Sliding Fee Discount Program Policy & Procedure12**
- IV. Fee Schedule Establishment and Maintenance Policy & Procedure18**
- V. Payment Posting Policy & Procedure22**
- VI. Charge Entry Policy & Procedure24**
- VII. Claims Submissions Policy & Procedure27**
- VIII. Billing Records Retention Policy & Procedure29**
- IX. Billing & Collection Policy & Procedure31**
- X. Medical Fee Waiving Policy & Procedure.....41**
- XI. Refusal to Pay Policy & Procedures43**
- XII. Sliding Fee Adjustment Code Policy & Procedures44**
- XIII. Good Faith Estimates48**

I. COASTAL HEALTH & WELLNESS MISSION, VISION, & VALUES

Our Mission

Providing high quality healthcare to all

Our Vision

Healthy people in healthy communities

Our Values

I CARE

Integrity- We are honest, trustworthy and transparent in all we do.

Customer Service- We are committed to providing exceptional customer service.

Accountability- We hold ourselves to high standards and take responsibility for our actions.

Respect- We uphold a standard of conduct that recognizes and values the contributions of all.

Equality- We equally value and serve all members of the community.

Coastal Health & Wellness does not discriminate any person based on race, color, national origin, sex, age, religion, or disability in our programs, services, or employment.

II. INSURANCE VERIFICATION POLICY & PROCEDURE

Policy Name: Insurance Verification Policy & Procedure

Policy Number: 2.01

Last Revised: June 23, 2024

Related Policy: Billing and Collections, Payment Policy

Related Documents:

In-scope Teams: Revenue Cycle, OEE, Patient Services, Dental Front Desk

Board Approval Date: June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to verify patient benefits, including any payers that may have payment responsibilities. While verifying and documenting patient and insurance responsibilities, specific processes are to be followed so that the information is accurate, stored correctly, easily accessible and documented in an understandable manner. These processes also promote the sending of claims to the proper payer source to avoid delays in payments

CHW makes every reasonable effort to enter contractual or other arrangements to optimize reimbursement of its costs with the appropriate agency(s) of the State which administers or supervises the administration of:

1. A State Medicaid plan approved under title XIX of the Social Security Act (SSA) [42 U.S.C.1396, et seq.] for the payment of all or a part of the center's costs in providing health services to persons who are eligible for such assistance; and
2. The Children's Health Insurance Program (CHIP) under title XXI of the SSA [42 U.S.C. 1397aa, et seq.] with respect to individuals who are State CHIP beneficiaries

CHW acknowledges the importance of identifying and documenting appropriate payer sources. The insurance verification process is performed by the teams accountable for performing billing and registration functions to promote:

1. Accurate identification of insurance on a patient's account
2. Coordination of benefits so that claims are submitted timely and accurately filed
3. Identifying any patient responsibility
4. Determining the payer of last resort for patients with multiple coverages/payers.

Patient benefits/appropriate payers are verified forty-eight (48) hours prior to the patient's appointment.

Medicaid eligibility can change from one month to the next. As a result, Medicaid eligibility is verified on the first business day of the month of the appointment.

1. Patients with a Medicaid application pending approval from the state are assigned an insurance carrier/status of "Medicaid pending" until Medicaid coverage is confirmed.

Procedure

The verification process for each department can vary. As such, specific instructions for verification are separated by area of specialty. Team members are assigned individual schedules to verify. Generally, schedules should be verified at least two days in advance. This allows the verification specialist, front desk, and call-center staff the time to clarify any issues of coverage with the insurance plan and the member prior to the appointment.

1. Patient registration is where information is recorded by verification team members. While determining and documenting patient and insurance responsibility, there are specific processes that must be followed to ensure that the information is stored correctly and in a manner that can be seen and understood by all. These processes also help to ensure that the claims are sent to the proper payer source.
2. Determine the primary payer source for medical visits. This information should be entered into the Insurance tab in the patient's registration. All other insurance carriers should be unchecked, even if they are active.
3. Click Insurance Eligibility to open the Additional Policy Information tab. Enter effective dates, coinsurance and deductible amounts, and any other relevant eligibility data. Click Active Coverage for active policies or Pending Verification for policies that require additional information to verify. Any policy that is known to be inactive should not be primary.
4. Ensure that the Financial Class corresponds to the primary payer.
5. Verify that the patient's name, date of birth, and ID number match the insurance plan if applicable.
6. Verify if any secondary or ancillary policies are active and enter Insurance Eligibility information in the Additional Policy information tab. Do not leave the policy checked, even if it is active.
7. Open the Appointments tab and find the appointment for which you are verifying insurance.
8. Right click on the appointment and choose Modify Appointment.
9. Build or apply any relevant case information.

10. Double click the space next to the line labeled Appointment. Enter any information that needs to be conveyed or has been conveyed to the patient for that particular appointment. The note should include the dollar amount the patient is responsible for and the payer source for the visit should be identified. End the note with the date and your initials. Click OK to save and close.

11. Save and exit the patient registration.

12. Medicaid Pending

12.1.1. Use to check if patient has applied

12.1.2. This report requires minimal input data.

12.1.3. Choose insurance

12.1.4. Click "View Report"

13. Creating and Applying Cases

Cases are created when a visit requires a different insurance carrier for a service rather than their primary medical insurance. For example, Traditional Medicaid does not cover sports physicals and patients must SelfPay for this. Therefore, you would want to apply a Self-Pay case to THAT APPOINTMENT only. This ensures that their primary medical insurance continues to be billed for all covered services and that no claims go out to the wrong carrier for non-covered services.

14. Ryan White Insurance Verification

Part of the verification process for Ryan White patients is to eliminate the possibility of other payer sources before assigning responsibility to the grant. Verification must check that each patient does not have access to Medicaid or Medicare and the front desk must ask the patient if they have insurance prior to every visit.

Patients are qualified for the grant at registration sites and are assigned character codes that can be entered into the Centralized Patient Care Data Management System (CPCDMS/Aries) to verify. They are then assigned copays based on their poverty level. If FPL is over 100%, they are assigned a cap. Medicare and Medicaid verification is done by either running the Emdeon Report daily or manually on each website (typically done when it's a same day appt). Please see instructions on how to access and run the "Emdeon Report" under the Insurance Verification section

15. Self-Pay & Sliding Scale

15.1.1. For office visits (including well exam, HRT, and STD testing) follow the Sliding Fee Scale.

15.1.2. Primary Care Verification

15.1.3. Traditional – no PCP assignment

- 15.1.4. Star/Star Plus – PCP should be CHW
- 15.1.5. No copay
- 15.1.6. Primary care, FP services, annual wellness, some immunizations
- 15.1.7. If active TPA is listed, Medicaid is secondary
- 15.1.8. As secondary, covers copays and co-ins for services covered under plan

16. Medicare NGS / Medicare Novitas Insurance Verification

- 16.1.1. No PCP assignment
- 16.1.2. Copay – slide if applicable
- 16.1.3. Primary care, FP services, annual wellness, some immunizations
- 16.1.4. As secondary, covers copay and co-ins for services covered under plan

17. Medicare Advantage Plans Insurance Verification

- 17.1.1. Replace original Medicare
- 17.1.2. May be PPO or HMO
- 17.1.3. May require PCP assignment
- 17.1.4. Must determine in or out of network
- 17.1.5. Copays and co-ins vary
- 17.1.6. Primary care, FP services, annual wellness, some immunizations
- 17.1.7. As secondary, covers copays and co-ins for services covered under plan

18. Private Insurance Verification

- 18.1.1. Must determine in or out of network
- 18.1.2. Ensure service is covered
- 18.1.3. Copays and co-ins vary
- 18.1.4. Deductible may apply
- 18.1.5. Has secondary plan?
- 18.1.6. Health funds or accounts?

19. CHC – Harris Health Insurance Verification

- 19.1.1. No copays
- 19.1.2. Must be referred by Harris Health

20. PHC Grant –Beaumont Clinics Only

- 20.1.1. Active for one year from certification
- 20.1.2. Primary care, FP services, annual wellness, immunizations

21. Ryan White Grant – LMC & BCC Clinics Only

- 21.1.1. Payer of last resort – Must check for Medicare & Medicaid
- 21.1.2. Eligibility verified through CPCDMS
- 21.1.3. If FPL over 100%, must verify copay & cap amount

22. Healthy Texas Women Program Insurance Verification

- 22.1.1. Covers females only for 3 providers visit for the plan year
- 22.1.2. Annual family planning and preventative healthcare visit
- 22.1.3. Contraceptive services, all methods except elective abortion & emergency contraception (includes follow-up and surveillance)
- 22.1.4. Preconception care
- 22.1.5. Basic infertility services
- 22.1.6. Certain screening, diagnostic, and treatment services:
- 22.1.7. Pregnancy testing
- 22.1.8. Screening and treatment of Cervical Intraepithelial Neoplasia, dx of cervical cancer
- 22.1.9. Screening and outpatient treatment of STD's and STI's
- 22.1.10. HIV testing
- 22.1.11. Breast cancer screening and dx
- 22.1.12. Recommended immunizations
- 22.1.13. Screening and treatment of postpartum depression
- 22.1.14. Diabetes screening and treatment
- 22.1.15. Hypertension screening and treatment
- 22.1.16. Screening and treatment of elevated cholesterol

Pediatric Insurance Verification

23. Traditional Medicaid

- 23.1.1. No PCP assignment
- 23.1.2. No copay
- 23.1.3. Acute care, FP services, well child, immunizations
- 23.1.4. If an active TPA is listed, Medicaid is secondary
- 23.1.5. As secondary, covers copays and co-ins for services covered under plan

24. Star & Star Plus Medicaid / CHIP

- 24.1.1. PCP should be CHW
- 24.1.2. MCD no copay / CHIP copay varies
- 24.1.3. MCD - Acute care, FP services, well child, immunizations
- 24.1.4. CHIP – Acute care, well child, NO FP, immunizations
- 24.1.5. If an active TPA is listed, plan is secondary
- 24.1.6. As secondary, covers copays and co-ins for services covered under plan

25. Private Insurance

- 25.1.1. Must determine in or out of network
- 25.1.2. Ensure service is covered
- 25.1.3. Copays and co-ins vary
- 25.1.4. Deductible may apply
- 25.1.5. Has secondary plan

26. Medicaid Pending

- 26.1.1. Check TMHP for coverage
- 26.1.2. Coverage Found
- 26.1.3. Add coverage to registration
- 26.1.4. Update collections staff

27. No Coverage Found

- 27.1.1. Newborn Under 3 months – keep Medicaid pending status
- 27.1.2. Newborn over 3 months – send to eligibility
- 27.1.3. Infants & older with Medicaid pending status less than 2 months – keep Medicaid pending status
- 27.1.4. Infants & older with Medicaid pending status over 2 months – send to eligibility

28. Sports Physicals

- 28.1.1. Uninsured follow slide
- 28.1.2. Private Insurance Copay applies
- 28.1.3. Traditional MCD – no coverage, self-pay
- 28.1.4. CHIP Plans
- 28.1.5. TCHP, AMG, Molina – Charge copay

28.1.6. CHC, UHC – No copay

29. Immunizations

29.1.1. Medicaid/Medicaid HMOs – No charge

29.1.2. Private insurance verifies independently – if no coverage, self-pay rate applies.

29.2. OB/GYN Verification

29.2.1. Copays and co-ins vary

29.2.2. We are a non-delivery provider. Phone call is required to determine coverage.

29.2.3. Deductible may apply

29.2.4. Has secondary plan?

29.2.5. Health funds or accounts?

30. Healthy Texas Women

30.1.1. Covers females only

30.1.2. Annual family planning and preventative healthcare visit

30.1.3. Contraceptive services, all methods except elective abortion & emergency contraception (includes follow-up and surveillance)

30.1.4. Preconception care

30.1.5. Basic infertility services

30.1.6. Certain screening, diagnostic, and treatment services:

30.1.7. Pregnancy testing

30.1.8. Screening and treatment of Cervical Intraepithelial Neoplasia, dx of cervical cancer

30.1.9. Screening and outpatient treatment of STD's and STI's

30.1.10. HIV testing

30.1.11. Breast cancer screening and dx

30.1.12. Recommended immunizations

30.1.13. Screening and treatment of postpartum depression

30.1.14. Diabetes screening and treatment

30.1.15. Hypertension screening and treatment

31. Specialty Services - Endocrinology/Geriatrics

31.1.1. When verifying for Specialty Services visits a phone call is required to all commercial plans (Aetna, BCBS, Cigna, Humana, etc.) to determine if visit is a specialist copay and/or if referral is required.

Create/apply case if applicable.

Vision Insurance Verification

32. Routine Vision

- 32.1.1. An optometrist diagnoses refractive vision errors. He writes prescriptions for eyeglasses and contact lenses. He can see patients for medical issues, but this is usually only if an ophthalmologist is not available.
- 32.1.2. A Certified Ophthalmological Assistant assists patients with glasses and contact lenses. The two appointment types you will see on her schedule are Dispense and Frame Style.
- 32.1.3. Associated terms: REE/CEE – Routine/Complete Eye Exam, CLS – Contact Lens, RX check
- 32.1.4. RX Check – Should be done within short period after REE/glasses dispensed. There is no charge.
- 32.1.5. CLS F/U – Appointment is to order supplies of contact lens after the trial period is over.

33. Medical Vision

- 33.1.1. An ophthalmologist is a Specialty MD. He/she screens, diagnoses, and treats diseases of the eyes. A Certified Ophthalmological Assistant assists the Ophthalmologist and also assists patients with glasses and contacts. The two appointment types for her are Visual Field and Dispense.
- 33.1.2. Associated terms: CMV – Cytomegalovirus (screening), Diabetic Retinopathy, Visual Field
- 33.1.3. Visual Field – A patient will be put on both Eva and Dr. Sawyer's schedule for a visual field exam. For Self-Pay/Sliding Scale patients, the cost is included in the price of Dr. Sawyer's visit.
- 33.1.4. Dispense Visits – For RW visits, check eligibility as usual, but no copayment is collected. Self-Pay, Sliding Scale, and Medicaid Dispense visits are included in the cost of the glasses.
- 33.1.5.
 - *HIV positive patients will usually be scheduled to see both doctors on the same day. This means you will have to ask for two/three separate benefits when calling to verify for these patients.

34. Traditional Medicaid and Medicaid MQMB

- 34.1.1. Cover both REE and medical vision visits with no copayment.
- 34.1.2. Adults 19 and up – one exam and 1 pair of glasses every TWO YEARS
- 34.1.3. Children through 18 – one exam and 1 pair of glasses every year
- 34.1.4. The date of their last exam and pair of glasses will be listed in the limits segments in TMHP.
- 34.1.5. MEDICAID QMB DOES NOT COVER REE OR GLASSES, ONLY MCR COINSURANCE.

35. Medicare

- 35.1.1. Medicare will cover ONLY medical vision visits, subject to coinsurance. Routine vision visits or contact lens exams will go the patient's secondary payer if applicable or will be the patient's responsibility.
- 35.1.2. Medicare/Ryan White client – Charge the Medicare coinsurance for the medical visit and the Ryan White copayment for the routine visit. Create/apply the Ryan White case to Dicks appointment
- 35.1.3. Medicare/MQMB client – No copayment is collected. Create/apply MQMB case to all routine visits.
- 35.1.4. Medicare/Self Pay client – Collect coinsurance as usual for medical visit. Collect Self Pay or Sliding Scale payment for routine visit. Create/apply Self-Pay/Sliding Scale case to routine appointments.

36. Ryan White

- 36.1.1. Ryan White will cover both the routine eye exam and medical vision visits for patients <300% of FPL. Ryan White will NOT cover glasses or contact lens fittings. Ryan White patients are provided with one pair of free glasses every two years, regardless of FPL. The vision staff is to determine eligibility for courtesy glasses. Ryan White patients only pay ONE copayment if BOTH visits are covered under Ryan White for the cost of BOTH visits and glasses if visit is scheduled on the same day.
- 36.1.2. Charge the usual Self Pay or Sliding Scale fees.

Commercial Insurance (BCBS, Aetna, Humana, UHC Private, etc.) Insurance Verification

37. Medical Vision

- 37.1.1. When calling to verify an Ophthalmology visit, you will ask for Specialist office visit benefits. *BCBS requires that you give the Ophthalmologist's NPI when verifying, or they will quote you out of network benefits.

38. Routine Vision

- 38.1.1. Some of these policies will have a routine eye exam available through the medical piece of their insurance. Deductibles and coinsurance may apply (usually only if Dr. Dicks is an out of network provider). Most of these plans will have vision vendors to handle routine eye exams, contact lens fittings, and discounts on glasses. We are out of network with most of these vendors.
- 38.1.2. You can call to verify if the client has OON benefits. When asking for routine vision benefits from the customer service representative ALWAYS ask if the eye exam is handled through the medical policy or through a vendor. If the representative says that the eye exam is ONLY covered as a screening with a routine preventative visit, or that refraction is NOT included, then the visit is NOT covered. Very rarely, if ever, will contact lens fittings or eyeglasses be covered through the medical policy. If a representative tells you that glasses or contact lens fittings are covered and gives you an allowance amount, call back and speak to another representative to verify.

38.1.3. When a patient has a non-contracted policy and no out of network benefits, has already used their routine vision benefit, or has a discount plan, the cost of the exam becomes the patient's responsibility. Ryan White will not pick up the cost of these services since they do have coverage. As a courtesy, call the patient to let them know that we are not in network, their benefits cannot be used here, or that they have already used their benefits. Inform them of the amount that they will owe at the time of the visit.

39. Star, Star Plus, & CHIP

39.1.1. Some insurance plans use vision vendors for routine and medical vision. Please see chart below for more information. You must verify if services are covered, if benefits are available, and if authorization is required. Create cases for alternate carriers and apply them appropriately.

Psychiatry Insurance Verification

40. For all commercial plans (Aetna, BCBS, Cigna, Humana, etc.) require a call to obtain benefit information. Some plans will use vendors for BH (Value Options, Optum, Magellan, etc.) for which you need to apply cases and preauthorization may be required.

Ryan White Grant Insurance Verification

41. Ryan White is billable for nutritional counseling and nutritional supplements. If a patient is on the schedule for Nutrition, follow the "[Ryan White Verification](#)" process under the Primary Care Verification section.

41.1.1. Copays do not apply to nutrition visits.

41.1.2. The patient is allowed 12 counseling visits per contract year by a licensed dietician.

41.1.3. The patient may receive up to a 90-day supply of supplements on a single visit.

Dental Insurance Verification

42. Dental Vendor for Medicaid patients can be found on TMHP.

43. For all commercial plans (Aetna, BCBS, Cigna, Humana, etc.) require a call to obtain vendor information. Once vendor is identified create/apply case with dental vendor.

All Other Payer Insurance Verification

44. All others are not billable and do not need verification.

III. SLIDING FEE DISCOUNT PROGRAM POLICY & PROCEDURE

Policy Name: Sliding Fee Discount Program Policy & Procedure

Policy Number: 3.01

Last Revised: June 23, 2024
Related Policy: Fee Scheduling Establishment and Maintenance
Related Documents: Sliding Fee Checklist, Patient Responsibility
In-scope Teams: Billing, OEE, Patient Services, Dental Front Desk
Board Approval Date: June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to establish a sliding fee discount schedule (SFDS) based on a patient's ability to pay for all services within the health center's approved scope of project regardless of the mode of delivery i.e., Column I, II, or III of Form 5 for which there is an established charge. The SFDS is established and implemented to ensure that uniform and reasonable fees and discounts are consistently and appropriately applied to all health center patients to address financial barriers to care. Eligibility for the SFDS will be based on income and family size and no other factors.

Sliding Scale is a discount program that is provided to all eligible clients based on the patient's ability to pay. Ability to pay is determined by the household income and family size.

1. CHW provides access to services without regard for a person's ability to pay for such services. The Clinic has established a Board-approved sliding fee discount program in accordance with current requirements.
2. The Board of Directors shall examine the nominal fees about whether they are a potential barrier to care. The quarterly patient satisfaction survey findings shall be shared with the Board of Directors as one means of assessing the nominal fee.
3. A full discount to individuals and families with annual incomes at or below those set forth in the most recent *Federal Poverty Guidelines (FPG)* [100% of the FPG], except that nominal charges for service may be collected from such individuals and families where imposition of such fees is consistent with project goals; and
 - 3.1. No sliding Fee discount to individuals and families with annual incomes greater than twice those set forth in such Guidelines [200% of the FPG].
 - 3.2. CHW's nominal fee for medical visits for patients at or under 100% of FPG is \$20.00.
4. CHW will update the Sliding Fee Discount Schedule related to changes in the Federally Poverty Guidelines. The Federal Poverty Guidelines are updated by the Department of Health and Human Services annually in mid-January. It is the goal of CHW to update their Sliding Fee Discount Schedule within three weeks of the release of the new guidelines. The review will conclude with the board providing guidance and direction to the CFO to ensure that this and other related policies and / or operating procedures are updated appropriately.

5. It is the policy of CHW to screen all patients to determine qualification for the center's sliding fee discount program.¹ To maintain its compliance with the requirement to serve all patients regardless of ability to pay, a center must also offer a sliding fee schedule of discounts to patients who are uninsured for all services or the particular service they seek; also, for underinsured patients, the center should apply the sliding fee discount to co-pays for covered services.
6. CHW utilizes multiple methods for informing patients of the availability of the SFDS in languages and at literacy levels that are appropriate for the patient population (currently in English and Spanish). The methods used to inform patients are as follows:
 - 6.1. Signage at all desks
 - 6.2. Brochures that are given to patients during initial visits
 - 6.3. CHW's website
7. CHW allows for a process and criteria for waiver of fees and nominal charges on a case-by-case basis.
8. CHW will prepare a schedule of fees to charge that allows for a "sliding fee discount" that will assure:
 - 8.1. That full fees to any patient with an annual income greater than 200% of the amount set forth in the Federal Poverty Guidelines (FPG)³ and gives a full discount for those making less than 100% of the amount set forth in the poverty guidelines.⁴
 - 8.2. Allows for a nominal fee may be charged to assure access.
 - 8.3. Includes reasonable efforts are made to collect payment from self-pay patients.⁵
 - 8.4. After the collection process has been followed, the uncollected amount should be written off to avoid the appearance of collectable accounts receivable that overstate the center's financial assets.
9. CHW will provide notice using more than one method to patients of the sliding fee discount that is appropriate for the language and literacy level of patients. Such notice should include what services outside the center's scope of project the patient may be billed for separately by the center or a third party.
10. CHW will review what other government or community programs that they may participate in to provide the following services to clients who are not necessarily eligible for Medicaid or CHIP: primary healthcare (PHC), family planning, breast and cervical cancer treatment, HIV/STD treatment, services for children with special healthcare needs and school-based services.²
11. Not all services are covered under the sliding fee program. Medical services provided "in-house" are eligible for a sliding fee discount. "In-house" refers to medical services provided at the clinic such as some labs, EKG's, some immunizations, and office visits. All Non-Vaccines for Children (VFC) or Non-Adult Safety Net (ASN) immunizations and/or injections, in addition to administration cost, and in house testing and procedures (e.g., INR (coagulation), A1C, biopsy, sutures) as well as IUD's, Birth Control Implants, and durable medical equipment are not included in the encounter rate and uninsured patients will be responsible for payment for these services/supplies.

12. Current Dental patients who qualify for the sliding fee discount program are required to pay for any associated dental lab and material costs for certain designated procedures unless they are above 200% of the federal poverty level and required to pay full charges.

Procedure

1. Staff will ensure that any fees or payments required by the center for health care services will be reduced or waived to assure that no patient will be denied such services due to an individual's inability to pay for such services.
2. The components of the sliding fee discount schedule are as follows:
 - 2.1.1. Definition of Income and Family Size
 - 2.1.2. Documents required to be provided by patients to support definition of income
 - 2.1.3. Determination of eligibility guidelines
 - 2.1.4. Structure of the Sliding Fee Discount Scale
 - 2.1.5. Definition of Income and Family Size Documents required to be provided by patients to support definition of income
 - 2.1.6. Determination of eligibility guidelines
 - 2.1.7. Structure of the Sliding Fee Discount Scale
3. CHW defines Income and Family Size as follows:
 - 3.1.1. Income: Money received by a household head and/or spouse/significant other for money received, especially on a regular basis, for work or through investments.
 - 3.1.2. Family: A family is defined as a person living alone or a group of two or more persons related by birth, marriage (including common-law), or adoption, which reside together and are legally responsible for the support of the other person. Unborn children are also included in family size.
 - 3.1.3. Family Size: The number of individuals in the family.
4. Acceptable forms of support for documentation of Income are as follows:
 - 4.1.1. Self-Declaration (if applicable)
 - 4.1.2. Check stubs for the current month (if paid weekly last 4 paystubs, if paid bi-weekly last 2 paystubs, if paid monthly last 3 paystubs)
 - 4.1.3. Current Tax Return or W2 Forms
 - 4.1.4. Employment Verification Form (EVF) or Letter from Employer
 - 4.1.5. Unemployment Benefits or Wage Detail from Workforce (if unemployed and not receiving unemployment)

- 4.1.6. Assistance Statement Verification (Supporter Statement that indicates unemployment and/or zero income) Retirement or Social Security Benefits Letter
- 4.1.7. Child Support
- 4.1.8. Public Assistance Verification letter
- 4.1.9. Letter from Homeless Shelter attesting income/no income
5. CHW's patient eligibility process for sliding fees is based on the following:
 - 5.1.1. Patient eligibility will be updated annually, and patients will be notified of their benefit term at the time of the application. CHW has records of assessing/re-assessing patient income and family size annually, except in situations where a patient has declined or refused to provide such information for further enrollment.
 - 5.1.2. CHW has supporting processes/operating procedures in place for assessing and verifying income and household size for patients that it uses to train personnel on the program and
 - 5.1.3. The SFDS is structured in a manner that adjusts based on a patient's ability to pay.
 - 5.1.4. A patient's eligibility is determined by FPL % based on the household's income and family size, using the current Poverty Level Guidelines showing income ranges and categories.
 - 5.1.5. Individuals and families with incomes at or below 100% of the FPG pay a "nominal charge." Individuals and families with incomes above 100% and at or below 200% of the FPG are charged amounts that are tied to graduated income levels. CHW has a minimum of 3 discount pay-classes above 100% and below 200%.
 - 5.1.6. Individuals and families with incomes above 200% of the FPG are not eligible for sliding fee discounts and thus are charged a full fee for services. These charges may be reduced by other funding sources that contain terms and conditions relating to specific services.
 - 5.1.7. CHW is permitted to utilize multiple sliding fee discount schedules. All schedules should be structured using the criteria previously mentioned in this section. Each Sliding Fee Discount Schedule will be based on either broad service types (such as medical and dental), distinct subcategories or service types (such as preventive dental and additional dental services), and/or on service delivery method (such as services provided by CHW directly vs. provided through a formal written contract). All sliding fee discount schedules by CHW will be approved by the Board of Directors annually.
 - 5.1.8. CHW will include information on every sliding fee discount schedule that indicates if a patient will be financially responsible for supplies that might be used during the provision of services. Services including DME, dental lab and dental material costs are examples of fees that are not included in the sliding fee discount. Some of these services may require payment in advance of ordering. Exceptions will be assessed and determined by the provider or department providing the service to the patient. More extensive treatments or procedures may also be excluded.
6. Patients with Third Party Coverage

- 6.1.1. It is CHW's Policy that the charge for each SFDS pay class is the maximum amount an eligible patient in that pay class is required to pay for a certain service, regardless of insurance status.
- 6.1.2. If an insured patient qualifies for the sliding fee discount schedule, the patient will be placed on the sliding fee discount schedule and charged the lesser of the amount due per the sliding fee discount schedule or the co-pay, deductible, etc.
- 6.1.3. CHW does and cannot require individuals to enroll in public or private insurance and this is not a factor when determining eligibility. However, it is CHW's Policy to educate patients based on their eligibility for public or private insurance for which they might qualify.
7. Services provided via formal referral arrangement
 - 7.1.1. For services provided through a formal referral arrangement (Form 5A, Column III), CHW will ensure that the fees for such services are either discounted as described in paragraph 5, sub-section 4 or discounted in such a manner that:
 - 7.1.1.1. Individuals and families with incomes above 100 percent of the current FPG and at or below 200 percent of the FPG receive an equal or greater discount for these services than if CHW's SFDS were applied to the referral provider's fee schedule, and Individuals and families at or below 100 percent of the FPG receive a full discount or a nominal charge for these services.
8. Patients who refuse to pay will be offered one of the following 3 options: sliding fee discount, a payment plan, or a grace period (See *Refusal to Pay Policy & Procedures*).
9. The 3-month CHW Presumptive Sliding Fee Eligibility program documentation deadline period shall be extended in case of declaration of emergencies or disaster by the national, state, or local officials, as well as reviewed based on case-by-case situation to reduce barriers to care. There will also be an extension of the presumptive sliding fee discount eligibility deadline under special circumstances.
10. Annual Audit: As a component of CHW's annual financial audit, the sliding fee discount program audit will be performed by External Auditors each Fiscal Year. The audit will include the following:
 - 10.1.1. A random sample of sliding fee applications will be selected from patients seen during the audit year.
 - 10.1.2. The auditor reviews all accompanying documents for accuracy and completeness.
 - 10.1.3. The approval/disapproval decision and the selection of the sliding fee discount category are also reviewed for accuracy by auditor.
 - 10.1.4. Any necessary sliding fee discount corrections will be documented and included in CHW Administrative General Sessions.

Patient Responsibilities for Sliding Fee Discounts

1. To satisfactorily comply with all regulations and policies, CHW's patients have responsibilities to cooperate with the SFDS requirements:
 - 1.1.1. They will need to complete the sliding fee discount application (Application for Health Care Assistance)

1.1.2. Provide requested personal information as listed under the “clinic responsibilities” to the Clinic.

Failure or denial to provide all required information will result in denial of eligibility.

2. If a supporting document is not available or is insufficient to determine eligibility, the patient will be placed on a 3-month Presumptive Eligibility. The goal of Presumptive Eligibility is to reduce barriers to immediate care for patients and to ensure patients have enough time to present required documentation for Sliding Fee Program. If the patient does not present the appropriate documentation to CHW within the 3 months, he/she will not be eligible for sliding fee discount program and will automatically be assigned standard office visit fee until the following year.
3. CHW will assess/reassess all patients for income and family size consistent with board-approved sliding fee discount program policies annually. This assessment will be documented in the practice management system. Patients are required to provide updated information at that time.

IV. FEE SCHEDULE ESTABLISHMENT AND MAINTENANCE POLICY & PROCEDURE

Policy Name: Fee Schedule Establishment and Maintenance Policy & Procedure

Policy Number: 4.01

Last Revised: June 23, 2024

Related Policy: Sliding Fee Schedule Policy

Related Documents: Master Fee Schedule Report

In-scope Teams: Billing, OEE, Patient Services, Dental Front Desk

Board Approval Date: June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to prepare a schedule of fees for the provision of its services consistent with locally prevailing rates or charges and that is designed to cover its reasonable costs of operation. The fee schedule will be developed based off the services approved by the CHW Governing Board of Directors.

The schedule of fees will be billed for services and supplies rendered/provided to patients to help ensure compliance with Federal, State, and other regulatory authorities.

1. CHW's fee schedule is intended to generate revenue to cover the costs associated with providing services and assist in ensuring the financial viability and sustainability of the health center.

Additionally, the fee schedule will be CHW's basis for seeking reimbursement from patients as well as third party payers. CHW's fee schedule will address all required and additional in scope services.

2. It is CHW's Policy that fees will be set to cover reasonable costs and will be consistent with locally prevailing rates or charges for the service. CHW will perform an analysis to associate costs with the provision of services for consideration in the pricing analysis. Locally prevailing charges will be analyzed through a possible review of the following:
 - 2.1. Commercial sources fee analyzer utilizing an adjustment corresponding with a geographic index
 - 2.2. Medicare Physician Fee Schedule available through CHW's MCR intermediary
 - 2.3. Private providers* in CHW's community or other, similarly situated communities
 - 2.4. Other information available
3. It is the policy of CHW to have a formal review of fees performed by an independent outside source every two to three (2-3) years. CHW will perform the analysis internally as codes are added or modified throughout the year.
 - 3.1. Each CPT, CDT, and HCPCS code entered into CHW's system, manually or via yearly coding updates, is assigned a fee.
 - 3.2. CHW uses various software products to determine its fees (which may include, but is not limited to, Physician's Fee Reference software for coding pricing, FAIR Health data, Wasserman Medical Publishers, LTD and Centers for Medicare and Medicaid Services National Physician Fee Schedule RVU data.
 - 3.3. CHW analyzes its fees using commercially available billing information that considers the geographic areas that CHW serves.

* CHW will seek the advice of private legal counsel when gathering fee-related information from other providers to ensure that it does not violate anti-trust regulations.

Procedure

1. CHW will develop and maintain a list of procedure (CPT/HCPC & CDT) codes representing services and supplies that will be available to patients. These codes, along with the related unit charges, will be maintained in NextGen, CHW's practice management system.
2. CHW will include a sample of at least one (1) private payor contract allowed amounts by procedure (CPT/HCPC & CDT) code associated with CHW when setting charges with the goal of setting charges at or above the maximum allowed amount, some exceptions may be warranted.
3. CHW will designate the method of determining current fees for services as a footnote on the fee schedule documents presented to the Governing Board. This includes source and calculation methodology.
4. CHW will develop and maintain a process to ensure individual FQHC Medicare G-code charge amounts that represent a Prospective Payment System (PPS) encounter are set based on a relationship to the detail procedure (CPT/HCPC & CDT) codes as defined by CHW.
5. CHW has elected to acquire, purchase, and facilitate access to equipment, supplies, and pharmaceuticals that are related to but not included in, the services provided by CHW as part of prevailing standards of care (examples would include eyeglasses and dentures). CHW chooses to do so to improve access to these items as a means of reducing barriers to care and improving health outcomes for its patient population. Revenue generated from these charges will be used to further the project objectives.
 - 5.1. CHW will determine a charge for these items by analyzing its costs and the needs of the target population.

CHW will, at its discretion, determine how to charge its patients for such supplies or equipment (for example, flat discounts, at cost, and/or on the sliding fee scale). Charge information for these items will be presented to the Board of Directors for approval. Prior to the provision of a service, patients will be informed by CHW of the following:

 - 5.1.1. When supplies or equipment related to a given service will result in separate charges from the service
 - 5.1.2. The total amount of out-of-pocket costs for these supplies or equipment
 - 5.1.3. Available payment plans
6. CHW will not charge different fees for the same procedure (CPT/HCPC & CDT) code unless exceptions are warranted. An example of an exception would be a charge for a vaccine as part of the Vaccines for Children Program where CHW does not incur a cost versus a charge for the same vaccine that is purchased and used for private stock.
7. CHW will not seek reimbursement for non-cost items as noted in Section 1862(a)(2) of the Social Security Act.
8. CHW will annually review fees and determine if updates are necessary based on the criteria above.

9. The Governing Board of Directors will review analysis prepared by CHW's management team and approve proposed fee updates and methodologies to allow an understanding of the impact to our patients and help to ensure a financial barrier to care does not exist.
10. CHW will perform self-assessments or engage a third-party to perform an evaluation of the fee schedule based on the criteria above at a minimum of every three (3) years.

References or Regulations

- [Health Center Program Compliance Manual | Bureau of Primary Health Care \(hrsa.gov\)](#)
- [Federally Qualified Health Centers \(FQHC\) Center | CMS](#)
- [Medicare Claims Processing Manual \(cms.gov\)](#)

V. PAYMENT POSTING POLICY & PROCEDURE

Policy Name: Payment Posting Policy & Procedure

Policy Number: 5.01

Last Revised: June 23, 2024

Related Policy: Charge Entry Policy, Billing and Collections Policy

Related Documents: Master Fee Schedule Report

In-scope Teams: Billing, OEE, Patient Services, Dental Front Desk

Board Approval Date: June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to assure the appropriateness of applying payments to CHW patient accounts with the following guardrails:

1. Patient and third-party payments will be posted and managed in the electronic practice management system (EPM).
2. Appropriate contractual and other adjustments are posted in the EPM.
3. Post all payments into the EPM within 5 business days upon receipt.
4. When possible, all electronic payments should be posted electronically. Only those carriers that do not allow electronic reports will continue to be posted manually.

Procedure

CHW accepts payments remitted and transferred directly from third-party payers by all payers offering electronic remittance advice (ERA) and electronic funds transfer (EFT). Remittances are accepted when available from the payer but are not posted until CHW accounting department staff confirms the remittance total to the funds transferred.

CHW accepts all non-electronic payments, including non-electronic third-party payer and patient checks, managed through CHW accounting department.

1. Payments are tracked and logged by accounting.
2. Payments received are posted based on deposit date.
3. All staff balance the batches assigned to them each day.
4. A transaction code is posted to the charge level on the account to identify the type of rejection.
5. Correspondence is relayed to the Billing staff member assigned to working on account follow up.

6. Health Center staff members posting payments are responsible for accurate posting on a line-item basis.
7. Health Center staff members who post payments are responsible for the transfer of the account balance to the patient or to secondary or tertiary payers (and manually or electronically mark the primary explanation of benefits unless the claim is an automatic crossover by the primary payer).
8. Payment posting is monitored closely to ensure timeliness and accuracy, as well as to identify opportunities for improvement.
9. Correspondence, including rejections, with no payment attached is flagged manually or electronically.
10. A summary of all batches posted is reconciled to the daily deposit and provided to the business office manager or designee.
11. The deposit date and posting date should match. These dates are sent with the deposit batch from accounting.
12. The batch number will include the deposit date for tracking purposes.
13. Payments received over the phone via credit or debit card will be charged and posted to the patient account by the medical records specialist or designated personnel from other departments outside of billing department.
14. Payments received thru mail will be posted by the patient support specialist and reconciled and deposited by finance administrative assistant.
15. Payments will be posted to the oldest date of service with an outstanding balance unless the patient specify what date of service the payment is for.
16. Payments received at time of Service will be posted to the patient account by the patient support specialist.
17. Payments from program or third-party funding sources will be deposited by the finance administrative assistant and posted by biller and/or payment posting specialist. Remittance advices will be posted to the encounter by the payment posting specialist for reconciliation of patient accounts. The posting will occur within 7 days of receipt. Payments will be reconciled monthly based on deposit reports from the finance department.

****Claim Status should be updated to reflect any claim that is not paid in full or needs additional follow up. This is the primary search method for billing staff working accounts and is imperative to the process.**

18. Unidentified/Incentive/Capitation Payments

18.1. CHW may receive payments that cannot be directly linked to a client's chart.

18.1.1. Those payments will be posted to the unidentified payments dummy account. These payments will be referred to the AR team for research and resolution.

18.2. CHW may receive incentive payments that are not directly linked to a client's chart.

18.2.1. Those payments will be posted in the incentive payments dummy account.

- 18.2.2. Incentive payments will be posted according to date of receipt.
- 18.3. CHW may receive capitation payments that cannot be directly linked to a client's chart.
 - 18.3.1. Those payments will be posted in the capitation payments dummy account.
 - 18.3.2. Capitation payments will be posted according to date of receipt.
- 19. Periodically, the business office manager or designee will select a sample of remittances from each payer

and compare the payments and contractual adjustments indicated on the remittance to the payments and adjustments posted in the practice management system. Any discrepancies between information on the remittance and payments and adjustments posted in the practice management system will be addressed by the business office manager or other supervisor and the staff person responsible for posting the payments and adjustments.

20. Small Balances Write Offs

- 20.1. Patient small balances will be automatically written off after 180 days.
- 20.2. Small balances are amounts equal to or less than \$5, which will cost more to bill for the balance than the value of the balance.
- 20.3. If the account balance is less than or equal to \$5, is more than 180 days old, and there are no insurance due balances, the account balance is written off. These transactions are marked with the applicable "small balance write off" code.
- 20.4. On a monthly basis, a report is generated that identifies accounts that meet these criteria.

VI. CHARGE ENTRY POLICY & PROCEDURE

Policy Name: Charge Entry Policy & Procedure

Policy Number: 6.01

Last Revised: June 23, 2024

Related Policy: Payment Posting Policy, Billing and Collections Policy

Related Documents: Master Fee Schedule

In-scope Teams: Billing, OEE, Patient Services, Dental Front Desk, Providers, Nursing, Lab

Board Approval Date: June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to capture the services performed by its providers in an accurate and timely manner.

It is the policy of CHW to facilitate timely and efficient billing and collections. To that end, CHW complies with predetermined lag times for key billing processes, including submissions of claims to third-party payers in a timely manner as a courtesy to patients and to receive prompt payment for services rendered.

Charges for services rendered should be accurately posted by Health Center staff within 5 days of the date of service.

CHW will take the appropriate steps to capture services performed for a patient in an accurate and timely manner. The charges are captured via electronic medical record system or paper superbill.

Procedure

1. Office Procedures

- 1.1. CHW providers are responsible for submitting all procedure and diagnosis codes on the same day when rendering services in the office, and 72 hours for services rendered out of the office.
- 1.2. Charge capture includes the following information for every patient encounter regardless of the site of service. (Note the practice management system provides several of these elements electronically.)
 - 1.2.1. Patient name
 - 1.2.2. Patient identification
 - 1.2.3. Date of birth
 - 1.2.4. Attending provider
 - 1.2.5. Place of service
 - 1.2.6. Date of service(s)
 - 1.2.7. Procedure code(s)
 - 1.2.8. Diagnosis code(s) – appropriately linked to procedure codes, if applicable
 - 1.2.9. Additional information as needed to process the charge
 - 1.2.10. Referring physician, if applicable
- 1.3. The provider documents all services rendered to the patient in the electronic medical record.
- 1.4. The provider completes charge documentation at the time the service is rendered.
- 1.5. Diagnosis “rule outs” are not permitted. A diagnosis must be made and coded based on information available and symptoms presented.
- 1.6. Providers must match procedure codes to the appropriate diagnosis codes using a numeric method and/or via the methodology provided by the practice management system for linking diagnosis codes when multiple procedure codes are used.
- 1.7. Providers are responsible for documenting and coding all procedure and diagnosis codes into the EHRS or on the charge ticket. Procedure and diagnosis codes are created for each unique patient visit.
- 1.8. Encounters or charge tickets with incomplete or illegible charge data are flagged or returned to the originating provider for completion to ensure expedient billing and collection.

2. Billing Staff Procedures

- 2.1. Timeliness and accuracy of charge coding and medical record documentation are regularly reviewed. Every effort is made to eliminate errors in registration, procedure and diagnosis coding and charge entry to ensure timely reimbursement.

- 2.2. Charges are posted in the practice management system within one business day of being received at the business office, through the electronic medical record or data entry by a staff member from a paper charge ticket.
- 2.3. Using available electronic or manual tools and resources, CHW staff are responsible for reviewing and editing charges before they are submitted.
 - 2.3.1. During the review process, any discrepancies are resolved immediately.
 - 2.3.2. If necessary, the provider rendering the service for which the charge is being billed is contacted in person, via an internal email communication regarding the charge.
 - 2.3.3. Providers have two business days to respond to questions about charges.
 - 2.3.4. Charge edits are resolved within three business days.
- 2.4. CHW staff submits prepared claims within two business days of charge entry.
- 2.5. CHW staff monitor the period of the claim's submission to payment by the payer.
- 2.6. The lag times for the following key processes are monitored by Billing staff. Outliers are reported to the service line directors. The key processes are:
 - 2.6.1. Date-of-service to date-of-charge submission versus documentation and coding must occur within a reasonable timeframe.
 - 2.6.2. Date-of-charge submission to date-of-claim submission
 - 2.6.3. Date-of-claim submission to date-of-payment by third-party payer

If applicable, additional key processes will be identified and monitor

VII. CLAIMS SUBMISSIONS POLICY & PROCEDURE

Policy Name: Claims Submission Policy & Procedure

Policy Number: 7.01

Last Revised: June 23, 2024

Related Policy: Payment Posting Policy, Billing and Collections Policy, Charge Entry Policy

Related Documents: Master Fee Schedule

In-scope Teams: Billing, OEE, Patient Services, Dental Front Desk, Providers, Nursing, Lab

Board Approval Date: June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to conform to industry standards to assure prompt billing and collections from insurance carriers and patients. Billing of claims are processed and followed up in a timely manner

Following the editing process, clean claims are sent electronically in real time or by the end of the business day.

2. Exception reports generated from the submission are worked on a same-day basis.
3. Claims are not suspended / held unless necessary.
4. Claims placed on hold status and monitored by the billing directors to ensure suspended/ held claims are resolved expediently.
5. CHW submits secondary claims in the event a patient maintains a secondary insurance policy and the primary insurance carrier does not pay the full amount of the charge. The secondary insurance carrier is billed for the remainder of the balance CHW makes best efforts to work with payers to crossover secondary claims automatically. If not, the primary explanation of benefits (EOB) is flagged manually or electronically and submitted to a CHW staff member to bill the secondary insurance carrier.
6. Within 24 hours of notification of responsibility of the secondary payer, the secondary claim(s) are submitted.
7. The full balance of primary and secondary claims submitted to third-party payers with whom the CHW does not participate may be transferred to patient responsibility.
8. For services covered under a capitated plan, charges are automatically adjusted by the practice management system. If a patient receives a service for which the patient is covered, but which is not included in the capitation agreement, a claim is sent to the third-party payer.

Procedure

1.

VIII. BILLING RECORDS RETENTION POLICY & PROCEDURE

Policy Name: Billing Records Retention Policy & Procedure

Policy Number: 8.01

Last Revised: June 23, 2024

Related Policy: Medical Records Policy, Patient Financial Policy

Related Documents: Release of Medical Records

In-scope Teams: Billing

Board Approval Date: June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to maintain original billing and financial documents in accordance with CHW medical records retention policies.

Confidentiality

- 1.1. Patients as well as the billing staff will be made aware that the electronic medical record and the information contained within are to be held in strict confidence. This will be done by providing a written privacy policy to all patients (or their legal guardian) and posting the privacy policy in a public area within CHW. HIPAA training upon hire and ongoing annual HIPAA refreshers will make the clinic staff aware of this.
- 1.2. A patient must give written permission for the release of medical information for billing purposes. A parent or legal guardian must supply this permission for a minor. The patient Financial Policy will be signed to give permission to release records as needed for billing purposes. The only exception to this is when records are released from provider-to-provider for continuing medical care for the patient.

2. Record Release and Retention

- 2.1. Original billing records such as EOBs, Patient Financial Statements, Signed Sliding Fee documentation shall be maintained in HIPAA secure storage in accordance with CHW medical records retention policies.
- 2.2. A billing Manager will review documents and approve the release of medical records to support patient charges or insurance or regulatory audits prior to the release of records.

Procedure

1.

IX. BILLING & COLLECTION POLICY & PROCEDURE

Policy Name: Billing and Collection Retention Policy & Procedure

Policy Number: 9.01

Last Revised: June 23, 2024

Related Policy: Medical Fee Waiving Policy, Refusal to Pay Policy, Sliding Fee Adjustment Policies

Related Documents: Patient Refund Request Form

In-scope Teams: Billing, Finance

Board Approval Date: June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to conform to industry standards to assure prompt billing and collections from insurance carriers and patients. Billing processes including but not limited to assignment of codes, electronic submission of claims, appeals for denied claims as well as collections processes are processed and followed up in a timely manner.

Although we do not utilize an outside collection agency, collection efforts are continued for a minimum of 120 days. These are conducted in an efficient, respectful, and culturally appropriate manner, that assures that procedures do not present a barrier to care, and patient privacy and confidentiality are protected throughout the process. At 120 days with no payment or activity on account the balance will be adjusted following the guidelines for aging of patient accounts.

It is CHW's policy to maximize revenue from public and private third-party payers and make reasonable efforts to obtain reimbursement from those parties, including public health agencies.

It is the goal of CHW to submit clean claims to third-party payers in a timely manner as a courtesy to patients and to receive prompt payment for services rendered.

CHW will participate in Medicaid, Medicare, CHIP, and as appropriate, other public and / or private assistance programs or health insurance. CHW has procedures in place to educate patients on health insurance options available to them based on their eligibility for insurance and / or related third party coverage.

All reasonable efforts to secure payment from patients for services rendered are made by billing and front desk to collect the payment in full. Payment plans are acceptable and offered when appropriate. Collection attempts are made and continued, and additional meeting with eligibility to determine if additional financial hardship is needed.

To assure data integrity, CHW will perform daily balancing and full monthly closing procedures as soon as reasonable after the last day of each month.

Patient Payments and Collections

- 1.1. Patients will be offered screening for program eligibility and/or sliding fee program.
 - 1.2. Dues from insured patient (co-payment, co-insurance and/or deductible):
 - 1.2.1. The co-payment, co-insurance or deductible is the minimum amount expected for the services provided and are requested at each visit. No patient will be refused service based on inability to pay.
 - 1.2.2. At each visit, the patient support specialist will notify the patient of the current amount due and any outstanding balance(s) and will attempt to collect on the balance(s), remind the patient of their financial obligation, and/or inform the patient of the financial arrangement option(s).
 - 1.3. Dues from self-pay patient:
 - 1.3.1. Patients are expected to make a payment before seeing the provider. The patient support specialist will request the payment upon check-in. No patient will be refused service based on inability to pay.
 - 1.3.2. At each visit, the patient support specialist will notify the patient of the current amount due and any outstanding balance(s) and will attempt to collect on the balance(s), remind the patient of their financial obligation, and/or inform the patient of the financial arrangement option(s).
 - 1.4. Patients who are unable to pay for their services on the day of the visit should be referred to [Refusal to Pay Policy and Procedure](#) to establish a financial arrangement option. Payment arrangements can be initiated by patient support specialist and must be approved by site lead and above at the clinic. The payment arrangements are only available on accounts with balances greater than \$25.00.
 - 1.5. A statement will be sent to the patient with outstanding balance due on their patient account. The patient has an option to pay by cash or with credit card at one of CHW location, mail in check or credit card information.
 - 1.6. CHW is committed to assuring that all reasonable collections efforts are made prior to writing off unpaid balances to bad debt. A minimum of 3 statements will be sent to patients with balances over \$25.00.
 - 1.7. CHW provides education to patients on insurance and, if applicable, related third party coverage options available to them.
2. Aging and Write-off
 - 2.1. Accounts with remaining balances (positive or negative) of less than one (\$1- \$10) dollars may be written off within a reasonable amount of time at billing and insurance verification coordinator discretion.

Procedure

1.
 - 2.2. All self-pay balances and patient owed after insurance paid that are greater than 180 days and/or 3 statements have been mailed out shall have their account verified that they have at least 3 statements, then the account shall be written off as bad debt.
 - 2.3. Accounts with balances greater than 365 days and in a bad debt status will be adjusted off an account as uncollectible.
 - 2.4. To be considered for write-off, the billing department must be able to demonstrate that adequate steps were taken to collect the amount due.
 - 2.5. Anything found questionable must have approval from the Chief Operating Officer.
3. Patient Complaints about Patient Fees
 - 3.1. The patient support specialist should explain the billing process to the patient.
 - 3.2. If the patient's concerns are not adequately addressed, the patient support specialist should refer the patient to site lead.
 - 3.3. Site lead will use their discretion in resolving the patient's concern. Patient concerns and resolutions must be noted on the EHR. Potential resolutions include, but are not limited to the following:
 - 3.3.1. Accepting partial payment for services that day and defer remainder of the balance to the next visit.
 - 3.3.2. Initiate arrangement for payment plan.
4. Refunds/Credits
 - 4.1. It is the goal of CHW to return all monies that are not due to the Health Center. These may include overpayments from patients or third-party payers. CHW is committed to complying with state and federal laws, as well as to minimize the impact that refunds have on receivables (i.e., refunds negate receivables) and management reports regarding business office performance.
 - 4.2. Overpayments are flagged at the time the payment is posted and the ticket is moved into overpayment status.
 - 4.2.1. CHW billing staff works these refunds ensuring the overpayment status if appropriate.
 - 4.2.2. The staff member completes a Refund Request Form to request the refund check be processed.
 - 4.2.3. A thorough review of the account is conducted to determine the cause of the credit balance.
 - 4.2.4. If a posting error caused the credit balance, a refund is not made.
 - 4.2.5. Thorough documentation of the refund is placed in the notes section of the patient's account.
 - 4.3. In addition to proactively refunding credits created during the posting process, the billing department is responsible for refunding outstanding credits.
 - 4.3.1. The accounts should be reviewed thoroughly.
 - 4.4. Credit invoices are identified and refunded to the patient, guarantor, or third-party payer within 30 days.

- 4.4.1. Any credits identified that can be transferred to another outstanding invoice are done within 30 days of creation date.
- 4.4.2. The oldest credits should be processed and refunded first.
- 4.5. If a credit balance occurs for a guarantor with multiple patients on the account and a debit balance remains on the total account, the credit is posted as an open balance payment.
- 4.6. Refunds are posted to the patient's account when the refund check is issued.
- 4.7. Requests for refund checks are submitted to the business office manager or designee in writing or via internal email on the Refund Request Form and require the designated supervisor's signature
- 5. Insufficient Fund Checks and Unredeemed Refund Checks
 - 5.1. Insufficient Fund Checks will be handled by the finance department.
 - 5.2. Refund checks written to patients that are not redeemed within 90 days, the finance department will reach out to the patient. If the patient is not reachable within a reasonable time period, the check will be voided
 - 5.2.1. Leave the credit balance on the patient account or
 - 5.2.2. Report to the Texas State Comptroller as unclaimed property by the finance department.
- 6. Changes in Assigned Billing Codes

- 6.1. The Billing Department does not change codes other than written procedure, or with permission from the attending provider.
- 6.2. If provider clarification is needed either because of an internal chart review or at the request of an insurance carrier, communication from billing leadership regarding the requested clarification will be made to the rendering provider. The communication will request appropriate documentation/charting and provide a clear, concise request for the clarification needed.
- 6.3. Any change or update to codes will have the reason for the code change appropriately documented and will comport with CHW's PMS procedure and appropriate coding guidelines (see AAPC and AHIMA standards). The reason for code changes will be appropriately documented.

7. Denials/ Rejections

- 7.1. All claims rejected by clearinghouse must be identified, corrected, and resubmitted within 5 business days. All claim denied by insurance should have valid reason behind the claim denial and appropriate action to be taken within reasonable time period. Below are the most common denial reasons:

7.1.1. Claim denied for incorrect information.

7.1.1.1. Incorrect provider information.

7.1.1.2. Incorrect coverage information.

7.1.1.3. Lack of information.

7.1.2. Claim denied as inclusive with the primary procedure

7.1.2.1. Some service covered with primary procedure; hence we need to write off the claim balance after primary CPT paid. This is important to watch for claims that go out with both a T1015 and a CPT code. If T1015 pays the encounter rate and the visit is paid in full, any balance should be adjusted off appropriately. However, if CPT is payable separately - will resubmit the inclusive procedure with modifier.

7.1.3. Claim denied as services not provided or authorized

7.1.3.1. File the claim along with appropriate authorization#.

7.1.3.1.1. If we do not have authorization #, sometimes we can appeal the claim along with necessary medical document. Confirm if the visit had an authorization.

7.1.3.1.2. If no authorization is on file, contact carrier and request retroactive authorization; resubmit claim.

7.1.3.1.3. If no authorization can be obtained, adjustment should be made.

7.1.4. Claim denied because of incorrect medical coding

- 7.1.4.1. Billing department email list of charts to be corrected to CHW provider. After the charts being corrected, billing staff reviews the charts to confirm correct information and resubmit/appeal the claim with correct diagnosis (DX) and CPT.
- 7.1.5. Claim denied due to invalid CPT code
 - 7.1.5.1. The claim should be filed with valid CPT. The billing department needs to contact EHR administrator to update the database if need.
- 7.1.6. Claim denied because primary insurance changed
 - 7.1.6.1. File the claim to patient primary insurance if additional coverage is on file.
 - 7.1.6.1.1. Check copy of the insurance card to see if additional coverage is listed (for example – TCHP will list primary coverage if it exists). Update registration, re-file claim.
 - 7.1.6.1.2. If we don't have patient primary insurance details, we need to call the patient and get the insurance information. Verify new coverage, update registration and re-file appropriate claims.
 - 7.1.6.1.3. If patient has no coverage, update visit to self- pay. Balance will be posted to patient's account. After the statement is sent out, the patient can make payment arrangements or refer to eligibility to verify additional payer sources.
- 7.1.7. Claim denied for coordination of benefits
 - 7.1.7.1. Patient needs to update the COB information to insurance. If patient has more than one insurance, patient needs to call the insurance and inform them which insurance is primary and secondary for patient. Update registration; refile claims appropriately. Check copy of the insurance card to see if additional coverage is listed (for example – TCHP will list primary coverage if it exists). If we can confirm term date with patient, we can contact carrier with term date; update registration; refile claims appropriately.
- 7.1.8. Claim denied for maximum benefits reached.
 - 7.1.8.1. File the claim to secondary along with denied EOB. If patient does not have secondary insurance, update visit to self- pay. Balance will be posted to patient's account. After the statement is sent out, the patient can make payment arrangements or refer to eligibility to verify additional payer sources.
- 7.1.9. Claim denied for retroactive termination date
 - 7.1.9.1. Contact the patient to verify updated coverage. If no coverage in place, change financial class to self- pay and invoice the patient. Payment plan option is available.
- 7.1.10. Claim denied for invalid referral number

- 7.1.10.1. The claim should be filed with valid referral number. If we do not have valid referral number, we can request the same from referring doctor and refile the claim with valid referral. (May apply for specialty services where patient has another PCP).
- 7.1.11. Claim denied for not covered by the patient's plan
 - 7.1.11.1. Update visit to self-pay. Balance will be posted to patient's account.
 - 7.1.11.2. After the statement is sent out, the patient can make payment arrangements or refer to eligibility to verify additional payer sources.
- 7.1.12. Claim denied due to dates of service past filing deadline (timely filing)
 - 7.1.12.1. Claims should be filed within the filing limit according to CHW guidelines. If the denial for TFL is received, we can appeal the claim with TFL proof.
 - 7.1.12.2. Confirm filing / batch information and resubmit claim with proof of timely filing. If no proof of timely filing exists, submit it to billing supervisor for adjustment.
- 7.1.13. Claim denied due to bundling inclusive
 - 7.1.13.1. Needs to differentiate the service by using appropriate modifier and DX code.
- 7.1.14. Claim denied due to primary insurance paid in full
 - 7.1.14.1. Need to adjust the claim balance. (T1015 plus CPT code – adjust off once full encounter rate is paid, if CPT is not payable individually).
- 7.1.15. Claim denied because CHW is not PCP on file with payor
 - 7.1.15.1. Contact carrier to confirm PCP was updated to CHW; if so, request retroactive date to accommodate claim. If not, contact patient and have them update the PCP to CHW and request retroactive date to accommodate visit date. Update visit and re-file appropriately. If unable to contact patient, make a note on EHR to have PCP updated prior to next visit.
- 7.1.16. Claim denied due to non-billable service or provider
 - 7.1.16.1. If a service and/or the provider is non billable, adjust visit.
- 8. Insurance Follow Up
 - 8.1. CHW Billing Department is required to follow up on all monies owed to the Health Center by third-party payers in a timely and effective manner.
 - 8.2. Insurance follow-up work is divided among CHW staff members equitably, based on the amount of work; according to the volume of accounts; work required by each payer as determined by the availability of automation, ease of communication, clarity of payment policies; and other factors that may dictate the time required to work the account.

- 8.3. CHW staff assigned the duty of insurance follow up are responsible for using all available resources and making all appropriate efforts to obtain outstanding payment on claims.
 - 8.4. CHW Billing management or designee generates and provides reports from the practice management system to support Health Center staff engaged in follow up.
 - 8.5. All actions taken on an account are documented, including the nature of the action, the date and the individual taking the action.
 - 8.6. It is the responsibility of CHW staff members engaged in follow up to track future work generated, such as reviewing an account 30 days after an appeal letter is sent. Every staff member involved should use the practice management system's automated follow-up tickler system, if available, or an automated calendar reminder system on his or her desktop.
 - 8.7. Insurance follow up is divided into two distinct, but related responsibilities: rejection or denial management and open or outstanding claims.
9. Rejected Claims
- 9.1. CHW Billing staff is required to identify, monitor, and act on all submitted claims that are rejected by third-party payers.
 - 9.2. CHW staff is assigned responsibility for reviewing and acting on all rejected or denied claims.
 - 9.3. These staff members receive all correspondence regarding rejections within one business day of receipt at the CHW (during the payment posting process).
 - 9.4. All rejections are reviewed and acted upon within 2-3 business days of receipt.
 - 9.5. CHW staff use all available resources to research and correct the claim, including but not limited to documentation of the service, medical literature, precertification and authorizations, procedure and diagnosis coding manuals and reference materials, specialty society policy statements, third-party payers' payment policies, and state and federal government coverage policies.
 - 9.6. Depending on the nature of the rejection, a claim is corrected and resubmitted, or an appeal is communicated over the telephone, via the payer's website or in writing to the third-party payer.
 - 9.7. Rejected claims are not resubmitted without documentation of the service. Identifying claims without documentation of the service must be brought to the attention of the CHW compliance officer immediately.
 - 9.8. Rejected claims are not resubmitted without corrections. Resubmitting a rejected claim without correcting it is grounds for disciplinary action.
 - 9.9. The business office monitors, and research claims denied by third-party payers to determine the causes of rejections. The claims rejection report, generated from a manual tracking report by CHW staff or automatically from the practice management system, is analyzed to determine specific claims that have been denied and the causes for denial. The analysis is used to train providers and staff.

- 9.10. CHW staff will work to proactively identify and resolve any problems with open or outstanding claims from third-party payers.
- 9.11. A CHW staff member assigned responsibility for insurance follow up runs an open claims report once a month, at minimum.
- 9.12. A report is run that identifies all outstanding claims, by payer and based on the payer's average payment timeframe. For example, if CHW expects all clean Medicare claims to adjudicate properly within 14 days, an open claims report is run for all outstanding claims more than 15 days. The report is organized in hierarchical order, with the highest dollar amount outstanding listed first.
- 9.13. The staff member responsible for this function uses all of his or her skills, experience, resources and knowledge to identify the status of an outstanding claim and act, as appropriate. Action may include, but is not limited to:
 - 9.13.1. Identifying that the claim was never received and resubmitting the claim.
 - 9.13.2. Submitting medical documentation to third-party payers if the claim is under review.
 - 9.13.3. Appealing an adverse decision for payment; or
 - 9.13.4. Communicating with the patient if the third-party payer is waiting for information from the patient.
10. If the staff member identifies a series of open claims from a specific date-of-claim transmission, the billing management or designee is alerted to determine if the source of the open claims was a failed batch (i.e., it failed to transmit to third-party payers). In that case, the affected claims are resubmitted immediately.
11. The staff member is expected to follow up on all outstanding claims until payment is received or a determination is made that the claim should be transferred to another party's responsibility or written off.
12. Write Offs
 - 12.1. CHW billing staff will track and monitor all monies that are written off from the original charge submitted to a third-party payer. Two distinct categories of write offs are handled and monitored separately: contractual amounts, which are considered uncollectible because of a contractual agreement with a third-party payer and non-contractual amounts, which are considered uncollectible for reasons other than the contract. See Adjustments for Sliding Fee Policy
 - 12.2. To track and monitor all write offs, CHW maintains a dictionary of detailed adjustment codes for contractual and noncontractual write offs. The noncontractual write-offs also may be attached with transaction message codes, if applicable.
 - 12.3. Billing office staff may write off contractual adjustment amounts when payments are posted to the practice management system. These write-offs must be done using appropriate contractual adjustment codes.
 - 12.4. From time to time, CHW staff may work on an account that has an outstanding balance with a health plan that cannot be collected. The reasons for CHW's inability to collect on the account may include,

but are not limited to, a missed timely filing or appeal deadline, or failure to obtain an appropriate authorization or referral. Billing management reviews adjustment batches daily for accuracy.

X. MEDICAL FEE WAIVING POLICY & PROCEDURE

Policy Name: Medical Fee Waiving Policy & Procedure

Policy Number: 10.01

Last Revised: June 23, 2024

Related Policy: Refusal to Pay Policy, Sliding Fee Program Policy

Related Documents:

In-scope Teams: Billing, OEE, Patient Services, Dental Front Desk

Board Approval Date: June 24, 2024

Policy

It is the policy of Coastal Health & Wellness (CHW) to ensure that the lack of means does not hinder care while additionally ensuring that each of our patients is treated equally and fairly.

Patients who present for care without the means for payment should follow first the policy for Sliding Fee Program to determine their poverty level. The patient who falls into a category that they are unable to fulfill must further discuss with the eligibility specialist on their current financial hardship (e.g. bankrupt, loss of employment, loss head of household) and/or medical hardship (e.g. terminally ill) to provide protection from undue financial burden. The fees may be reduced or waived all together.

2. It is CHW's Policy to identify specific circumstances for patients when CHW will waive or reduce fees or payments required by the center due to any patient's inability to pay. CHW's waiver process is as follows:
3. All attempts are made by billing and front desk to collect the payment in full. In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by eligibility, billing or designated staff. Any waiving of charges should be documented in the patient's file along with an explanation.
4. Patients that are screened and identified as homeless may fall into a category also known as CHW Care. Patients approved under CHW Care are allotted under a \$0 fee for "immediate medical needs". All other services that don't fall under this criterion will be charged under a category I.
5. Other waiver criteria include but is not limited to the following:
 - 5.1. Chronic illness
 - 5.2. Financial problems related to transportation or other unexpected expenses
 - 5.3. Natural disasters
 - 5.3.1. House fire
 - 5.3.2. Loss of primary income sources
 - 5.3.3. Death of a family member defined above
 - 5.4. The site lead and above may make an exception in the fees once the financial hardship is established. Documentation of the required fee, the amount of fee to be waived and the specific reason and length of hardship must be documented in the patient record. All documentation must be completed, and the additional hardship will be in effect for a period of up to 3 months and then re-evaluated.
 - 5.5. It is the responsibility of front office department to follow guidelines to prevent and detect the occurrence of fraud and abuse of medical fee waiving.
 - 5.6. In the case of patient deceases and a copy of death certificate is provided, the outstanding balance on deceased patient account shall be waived or written off by billing department.
 - 5.7. The decision to waive fees will be applied and made available consistently to all qualified patients

XI. REFUSAL TO PAY POLICY & PROCEDURES

Policy Name: Refusal to Pay Policy & Procedure

Policy Number: 11.01

Last Revised: June 23, 2024

Related Policy: Medical Fee Waiving Policy; Sliding Fee Program Policy

Related Documents: Registration Form; Payment Plan Form

In-scope Teams: Billing, OEE, Patient Services, Dental Front Desk

Board Approval Date: June 24, 2024

Policy

In accordance with the mission of Coastal Health & Wellness (CHW) and as a Federally Qualified Health Center (FQHC), it is the policy of CHW to ensure that the lack of means does not hinder care while additionally ensuring that each of our patients are treated equally and fairly. This policy provides guidance for identifying and handling refusal or unwillingness to pay.

CHW distinguishes the difference between refusal to pay and inability to pay.

CHW notifies patients that refuse to pay that:

- 1.1. Amounts owed and the time recommended to make such payments.
- 1.2. They will receive statements for their services.
- 1.3. CHW offers other assistance such as meeting with a financial counselor, establishing payment plans, and looking for additional programs that may assist the patient.
- 1.4. Some optional services, such as special dental services, contact lenses, referred out services, or supplies will not be given for patients that completely refuse to pay or comply with Sliding Scale policies.
2. A patient is deemed unwilling to pay if they:
 - 2.1. Declare they will not pay for anything at the time of service.
 - 2.2. Have a balance due more than \$200 and have not made a payment within the last 3 months.
 - 2.3. Refuse or fail to make a payment as agreed in the formal payment plan after a payment plan has been signed.
 - 2.4. Refuse to meet with an eligibility specialist to have their financial status re-evaluated.

Patients who express an unwillingness or refuse to pay will be referred to a billing eligibility specialist to assess their current financial and/or medical hardship status as per CHW's policy.

2. CHW provides several options to patients to pay, and those options include:
 - 2.1. Payment plans
 - 2.2. Waiver policies, and
 - 2.3. Financial counseling.
3. CHW does not choose to limit or deny services if accounts are unpaid.
4. All patients who present for care without the means for payment should follow first the policy for sliding fee program to determine their poverty level; specifically filling out the sliding fee discount program registration form and income documentation (refer to *Sliding Fee Adjustment Code Policy & Procedures*).
5. A patient who falls into a category that they are unable to fulfill must further discuss with the billing/ eligibility specialist on their current financial hardship (refer to Medical Fee Waiving Policy).
6. If a patient verbally expresses an unwillingness to pay, they will be made aware of the option to apply for the sliding fee discount program and/or they will be informed of the option to set up a payment plan for amounts owed to CHW.
7. If a patient leaves the premises without paying for services, applying for the sliding fee discount program or establishing a payment plan, a billing alert shall be documented by the front office personnel. The patient will then be notified regarding their financial responsibility either via phone call and/or mailing statement.
8. If the patient does not try to pay or fail to respond within 60 days, this constitutes refusal to pay.
9. If the patient who has been deemed unwilling to pay presents with an acute medical problem that requires immediate attention, the patient will receive care as scheduling allows without regard to ability to pay.
 - 9.1. The patient will be informed of the current balance owed to CHW and made aware of the expectation for future payment.

XII. SLIDING FEE ADJUSTMENT CODE POLICY & PROCEDURES

Policy Name: Sliding Fee Adjustment Policy & Procedure

Policy Number: 12.01

Last Revised: June 23, 2024

Related Policy: Sliding Fee Program Policy, Billing and Collections Policy, Discount Eligibility Schedule

Related Documents: CHW Registration Form

In-scope Teams: Billing, Patient Services, HITT

Policy

In accordance with the mission of Coastal Health & Wellness (CHW), a Federally Qualified Health Center (FQHC), it is the policy of CHW to ensure no one is denied care based on their inability to pay.

To maintain its compliance with the requirement to serve all patients regardless of ability to pay, CHW offers a sliding fee schedule of discounts to patients who are uninsured for all services and/or the particular service they seek. For underinsured patients, CHW offers sliding fee discounts to co-pays/co-insurances for covered services.

It is the policy of CHW to provide full or partial discounts for all services provided to patients based on their inability to pay. Eligibility is assessed and determined according to the CHW Sliding Fee Discount Policy & Procedure approved by The Governing Board ("The Board") and using the current year's Discount Eligibility Schedule/Sliding Fee Discount Schedule (SFDS).

The SFDS is calculated based on the Federally Poverty Guidelines (FPG). The FPGs are updated by the Department of Health and Human Services annually in January.

All uninsured and underinsured patients with self-pay balances after claims are adjudicated by a 3rd party payor who have been evaluated and meet eligibility criteria, will have their fee identified and documented in NextGen, CHW's designated Electronic Practice Management (EPM) System. Adjustments will be made to in scope encounters using Sliding Fee Adjustment (SFA) code.

CHW screens patients to determine qualification for the center's Sliding Fee Discount Program.

2. The Health Information Technology Team (HITT) updates the *Sliding Fee Verification* tablespace in NextGen (See Illustration A) annually with the criteria derived from the current year's Discount Eligibility Schedule/Sliding Fee Discount Schedule (SFDS) created by the Revenue Cycle Management (RCM), billing team. (See Illustration B)

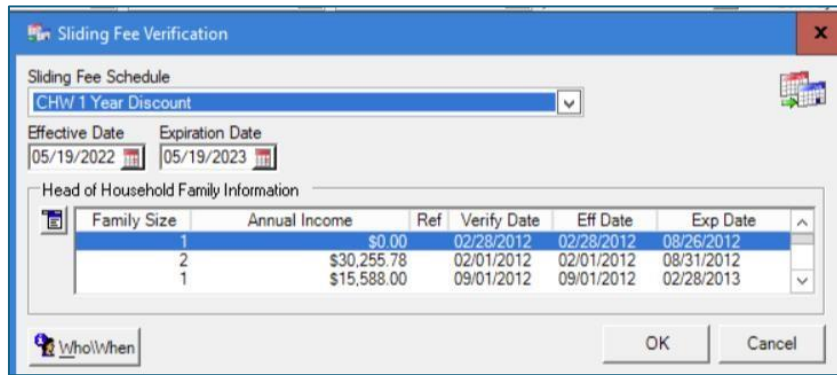



Illustration A: Sample Sliding Fee Verification Tablespace in NextGen

APPENDIX A
Coastal Health & Wellness
9850-C, Suite C-103, Emmett F. Lowry Expressway, Texas City, Texas 77591
CHW HRSA No. H80CS00344



**Coastal Health & Wellness Discount Eligibility (Sliding Fee) Schedule
2024/2025**

Household / Family Size (#)	Discount 100		Discount 80		Discount 60		Discount 40		Discount 20		Discount 0		
	0% Patient Responsibility		100% FPG		20% Patient Responsibility		125% FPG		40% Patient Responsibility		150% FPG		
	From	To	From	To	From	To	From	To	From	To	Greater Than		
1	0	\$15,060	\$15,061	\$18,825	\$18,826	\$22,590	\$22,591	\$26,355	\$26,356	\$30,120	\$30,120	\$3,765	\$15,060
2	0	\$20,440	\$20,441	\$25,550	\$25,551	\$30,660	\$30,661	\$35,770	\$35,771	\$40,880	\$40,880	\$5,110	\$20,440
3	0	\$25,820	\$25,821	\$32,275	\$32,276	\$38,730	\$38,731	\$45,185	\$45,186	\$51,640	\$51,640	\$6,455	\$25,820
4	0	\$31,200	\$31,201	\$39,000	\$39,001	\$46,800	\$46,801	\$54,600	\$54,601	\$62,400	\$62,400	\$7,800	\$31,200
5	0	\$36,580	\$36,581	\$45,725	\$45,726	\$54,870	\$54,871	\$64,015	\$64,016	\$73,160	\$73,160	\$9,145	\$36,580
6	0	\$41,960	\$41,961	\$52,450	\$52,451	\$62,940	\$62,941	\$73,430	\$73,431	\$83,920	\$83,920	\$10,490	\$41,960
7	0	\$47,340	\$47,341	\$59,175	\$59,176	\$71,010	\$71,011	\$82,845	\$82,846	\$94,680	\$94,680	\$11,835	\$47,340
8	0	\$52,720	\$52,721	\$65,900	\$65,901	\$79,080	\$79,081	\$92,260	\$92,261	\$105,440	\$105,440	\$13,180	\$52,720
9	0	\$58,100	\$58,101	\$72,625	\$72,626	\$87,150	\$87,151	\$101,675	\$101,676	\$116,200	\$116,200	\$14,525	\$58,100
10	0	\$63,480	\$63,481	\$79,350	\$79,351	\$95,220	\$95,221	\$111,090	\$111,091	\$126,960	\$126,960	\$15,870	\$63,480
11	0	\$68,860	\$68,861	\$86,075	\$86,076	\$103,290	\$103,291	\$120,505	\$120,506	\$137,720	\$137,720	\$17,215	\$68,860
12	0	\$74,240	\$74,241	\$92,800	\$92,801	\$111,360	\$111,361	\$129,920	\$129,921	\$148,480	\$148,480	\$18,560	\$74,240
13	0	\$79,620	\$79,621	\$99,525	\$99,526	\$119,430	\$119,431	\$139,335	\$139,336	\$159,240	\$159,240	\$19,905	\$79,620
14	0	\$85,000	\$85,001	\$106,250	\$106,251	\$127,500	\$127,501	\$148,750	\$148,751	\$170,000	\$170,000	\$21,250	\$85,000
15	0	\$90,380	\$90,381	\$112,975	\$112,976	\$135,570	\$135,571	\$158,165	\$158,166	\$180,760	\$180,760	\$22,595	\$90,380
16	0	\$95,760	\$95,761	\$119,700	\$119,701	\$143,640	\$143,641	\$167,580	\$167,581	\$191,520	\$191,520	\$23,940	\$95,760
1+ for each add'l family member add (to max.)		\$5,380		\$6,725		\$8,070		\$9,415		\$10,760		\$12,105	

Effective Date 4/1/2024

Source: HHS Poverty Guidelines, 2024

Illustration B: 2024/2025 CHW Discount Eligibility Schedule

3. NextGen, CHW's designated Electronic Practice Management (EPM) System, automatically calculates the Sliding Fee Adjustment (SFA) amount based on the patient's gross household income and family size sourced from the CHW Registration performed by Patient Services (PS).
4. Sliding Fee Adjustments will automatically be posted at the encounter level on the patient account in NextGen for in scope date(s) of service within one business day according to the sliding fee percentage to which the patient qualified.
 - 4.1. Sliding Fee Adjustment (SFA) code will automatically append to the encounter(s) for the duration of the assessment period.

XIII. GOOD FAITH ESTIMATES

Policy Name: Good Faith Estimate Policy & Procedure

Policy Number: 13.01

Last Revised: June 23, 2024

Related Policy: Sliding Fee Program Policy, Billing and Collections Policy

Related Documents:

In-scope Teams: Billing

Board Approval Date: June 24, 2024

Policy

In accordance with the mission of Coastal Health & Wellness (CHW) and as a Federally Qualified Health Center (FQHC), it is the policy of CHW to comply with a Patient's right to receive a "Good Faith Estimate" (GFE) explaining how much your medical care will cost.

Under the law, health care providers need to provide patients who don't have insurance or who are not using insurance with an estimate of the bill for medical items and services.

Our patients have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, etc.

Make sure patients are aware and CHW provides a Good Faith Estimate in writing at least 1 business day before their medical service or item. Patients can also ask their health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

Patients receiving a bill that is at least \$400 more than your Good Faith Estimate can dispute the bill. The Billing Manager is responsible for researching any patient concerns regarding a GFE. The clinical leaders will respond to a patient's concern within 5 business days of receipt.

A copy or picture of your Good Faith Estimate shall be saved in the patient's record. For questions or more information about Good Faith Estimates, visit www.cms.gov/nosurprises or contact our Billing and Collection Specialist at (409) 938-2248 or email@gchd.org.

Procedure

CHW provides patients with a Good Faith Estimate in writing at least 1 business day before their scheduled medical service or item.

Patients can also request from CHW a Good Faith Estimate before scheduling an item or service.

[Back to Agenda](#)



Coastal Health & Wellness
2025 Medical & Behavioral Health Fee Schedule
 Proposed Effective Date: 5/1/2025

CPT CODE	DESCRIPTION	2024 FEE SCHEDULE	2025 PROPOSED FEES	DIFFERENCE
Self Pay Fees				
	Nominal Fee Minimum Fee - 0% Responsibility	\$20.00	\$20.00	\$0.00
	Deposit Payment - 20% Responsibility	\$25.00	\$25.00	\$0.00
	Deposit Payment - 40% Responsibility	\$30.00	\$30.00	\$0.00
	Deposit Payment - 60% Responsibility	\$35.00	\$35.00	\$0.00
	Deposit Payment - 80% Responsibility	\$45.00	\$45.00	\$0.00
	Deposit Payment - 100% Responsibility (required at checkin)	\$55.00	\$55.00	\$0.00
	Retck Svc CG Returned check service charge	\$30.00	\$30.00	
New Patient Office Visit				
99202	New Patient Visit – Low Complexity	\$206.40	\$105.00	(\$101.40)
99203	New Patient Visit – Moderate Complexity	\$258.60	\$164.00	(\$94.60)
99204	New Patient Visit – Moderate/High	\$392.00	\$246.00	(\$146.00)
99205	New Patient Visit – High Complexity	\$548.20	\$324.00	(\$224.20)
G0438	Medicare Annual Wellness Visit (Initial)	\$345.60	\$242.00	(\$103.60)
Established Patient Office Visit				
99211	Established Patient Visit – Minimal (Nurse Visit)	\$45.60	\$35.00	(\$10.60)
99212	Established Patient Visit – Low Complexity	\$110.80	\$83.00	(\$27.80)
99213	Established Patient Visit – Moderate Complexity	\$177.00	\$134.00	(\$43.00)
99214	Established Patient Visit – Moderate/High	\$255.60	\$189.00	(\$66.60)
99215	Established Patient Visit – High Complexity	\$414.00	\$264.00	(\$150.00)
G0439	Medicare Annual Wellness Visit (Subsequent Year)	\$274.40	\$191.00	(\$83.40)
New Patient Preventive Visits				
99381	Well Child less than 1year	\$168.60	\$136.00	(\$32.60)
99382	Well Child 1 - 4 years	\$295.00	\$141.00	(\$154.00)
99383	Well Child 5 - 11 years	\$312.20	\$147.00	(\$165.20)
99384	Well Child 12 - 17 years	\$365.20	\$167.00	(\$198.20)

99385 Well Adult 18 - 39 years	\$403.80	\$162.00	(\$241.80)
99386 Well Adult 40 - 64 years	\$415.60	\$187.00	(\$228.60)
99387 Well Adult 65 years and over	\$428.00	\$202.00	(\$226.00)
G0402 Initial Preventive Exam	\$326.20	\$242.00	(\$84.20)
Established Patient Preventive Visit			
99401 Preventive Counseling – 15 Min		\$0.00	
99391 Well Child less than 1year	\$219.60	\$122.00	(\$97.60)
99392 Well Child 1 - 4 years	\$219.00	\$130.00	(\$89.00)
99393 Well Child 5 - 11 years	\$234.20	\$130.00	(\$104.20)
99394 Well Child 12 - 17 years	\$255.60	\$142.00	(\$113.60)
99395 Well Adult 18 - 39 years	\$304.00	\$145.00	(\$159.00)
99396 Well Adult 40 - 64 years	\$293.80	\$156.00	(\$137.80)
99397 Well Adult 65 years and over	\$322.40	\$167.00	(\$155.40)
New Patient Home Based Visit			
99341 New Home Visit – Simple Needs (15 Minutes)	\$118.00	\$72.00	(\$46.00)
99342 New Home Visit – Low Complexity (30 Minutes)	\$162.00	\$115.00	(\$47.00)
99344 New Home Visit – Moderate Complexity (60 Minutes)	\$177.00	\$207.00	\$30.00
99345 New Home Visit – High Complexity (75 Minutes)	\$400.00	\$292.00	(\$108.00)
Established Patient Home Based Visit			
99347 Home Visit – Established Patient, Simple Needs (20 Minutes)	\$89.00	\$66.00	(\$23.00)
99348 Home Visit – Established Patient, Low Complexity (30 Minutes)	\$214.80	\$112.00	(\$102.80)
99349 Home Visit – Established Patient, Moderate Complexity (40 Minutes)	\$302.20	\$185.00	(\$117.20)
99350 Home Visit – Established Patient, High Complexity (60 Minutes)	\$544.00	\$268.00	(\$276.00)
G0179 Home Health Re-certification		\$62.00	
G0180 Home Health Certification		\$79.00	
G0181 Home Health Supervision		\$154.00	
Behavioral Health			
90791 Psychiatric Evaluation	\$225.00	\$253.00	\$28.00
90792 Psych Eval w/ Medical Services	\$334.00	\$284.00	(\$50.00)
90832 Psychotherapy – 30 Min	\$179.20	\$120.00	(\$59.20)
90834 Psychotherapy – 45 Min	\$157.80	\$158.00	\$0.20
90837 Psychotherapy – 60 Min	\$152.00	\$234.00	\$82.00

90839	Crisis Therapy – Initial 60 Min	\$225.00	\$225.00	\$0.00
90840	Crisis Therapy – Each Add'l 30 Min	\$75.00	\$110.00	\$35.00
90846	Family Therapy (No Patient)	\$155.00	\$156.00	\$1.00
90847	Family Therapy (With Patient)	\$155.00	\$156.00	\$1.00
90853	Group Therapy	\$117.00	\$43.00	(\$74.00)
96156	Behavioral Health Assessment	\$274.00	\$150.00	(\$124.00)
96158	Behavioral Health – 30 Min	\$80.00	\$103.00	\$23.00
96159	Behavioral Health – Add'l 15 Min	\$109.00	\$36.00	(\$73.00)
96164	Behavioral Health Group – 30 Min	\$52.00	\$16.00	(\$36.00)
96165	Behavioral Health Group – Add'l	\$25.00	\$8.00	(\$17.00)
96167	Family Behavioral Health – 30 Min	\$296.00	\$110.00	(\$186.00)
96168	Family Behavioral Health – Add'l	\$118.00	\$40.00	(\$78.00)
G0445	Intensive Behav Counseling – 30 Min	\$111.60	\$48.00	(\$63.60)
96202	Multi-Family Training – 60 Min	\$107.00	\$36.00	(\$71.00)
96203	Multi-Family Training – Add'l	\$45.00	\$9.00	(\$36.00)
Chiropractic Care				
98940	Chiropractic adjustment for 1–2 areas of the spine.	\$53.00	\$41.00	(\$12.00)
98941	Chiropractic adjustment for 3–4 spinal regions.	\$71.00	\$59.00	(\$12.00)
98943	Chiropractic treatment for joints outside the spine (arms, legs, etc).	\$55.80	\$0.00	(\$55.80)
97014	E-Stim Therapy	\$28.00	\$0.00	(\$28.00)
97035	Ultrasound Therapy	\$50.00	\$21.00	(\$29.00)
97530	Therapeutic Activities	\$96.00	\$53.00	(\$43.00)
97110	Therapeutic Exercises	\$63.60	\$44.00	(\$19.60)
S8990	Maintenance Chiropractic Care	\$50.00	\$0.00	(\$50.00)
97140	Manual Therapy	\$65.80	\$41.00	(\$24.80)
Care Management				
97552	Group Training for Caregivers	\$76.00	\$34.00	(\$42.00)
99439	Extra Chronic Care Support (Staff – Each Additional 20 Minutes)	\$137.60	\$70.00	(\$67.60)
99483	Memory and Cognition Care Planning	\$450.00	\$382.00	
99487	Complex Chronic Care Management (First 60 Minutes)	\$163.40	\$198.00	\$34.60
99490	Chronic Care Support (20 Minutes)	\$118.00	\$91.00	(\$27.00)
99491	Chronic Care by Doctor or NP (First 30 Minutes)	\$125.00	\$124.00	(\$1.00)

99495	Transition Care After Hospital Stay (Within 14 Days)	\$448.20	\$303.00	(\$145.20)
99496	Transition Care After Hospital Stay (Within 7 Days)	\$453.20	\$410.00	(\$43.20)
99497	Advance Care Planning (30 Minutes)	\$206.60	\$120.00	(\$86.60)
G0019	Community Health Support for Social Needs (First 60 Minutes)	\$162.00	\$118.00	(\$44.00)
G0022	Extra Support Time (Each Additional 30 Minutes)	\$101.00	\$73.00	(\$28.00)
Special Services				
	STD/HIV STD Referral		No Charge	
90853	Tobacco Group Counseling	\$117.00	\$43.00	(\$74.00)
99499	Brief Consultation		\$30.00	
G0403	Ekg For Medicare Initial Prevent Exam	\$60.00	\$21.00	(\$39.00)
92227	Retinal Imaging	\$74.00	\$26.00	(\$48.00)
99173	VISUAL ACUITY SCREEN	\$23.00	\$35.00	\$12.00
92551	PURE TONE HEARING TEST, AIR	\$25.00	\$38.00	\$13.00
Incision and Drainage Procedures				
10060	Incision and drainage of abscess, single	\$291.20	\$187.00	(\$104.20)
10061	Incision and drainage of abscess, complicated or multiple	\$630.80	\$313.00	(\$317.80)
10120	Incision and removal of a foreign object from subcutaneous tissues	\$387.40	\$221.00	(\$166.40)
10140	Incision and drainage of hematoma	\$372.40	\$247.00	(\$125.40)
10160	Puncture and aspiration of abscess	\$370.80	\$190.00	(\$180.80)
Paring or Cutting				
11055	Trim Skin Lesion	\$187.20	\$102.00	(\$85.20)
Debridement Procedures				
11000	Debridement of extensive eczematous or infected skin (up to 10% of body surface)	\$90.00	\$86.00	(\$4.00)
Biopsy Procedures				
11102	Biopsy, skin and subcutaneous tissue, single lesion	\$231.80	\$144.00	(\$87.80)
11103	Biopsy, skin and subcutaneous tissue, each additional lesion	\$103.00	\$72.00	(\$31.00)
11104	PUNCH BX SKIN SINGLE LESION		\$179.00	
11105	PUNCH BX SKIN EA SEP/ADDL		\$87.00	
Skin Tag Procedures				
11200	Remove multiple fibrocutaneous skin tags, up to 15	\$215.00	\$136.00	(\$79.00)
11201	Remove multiple fibrocutaneous skin tags, each additional 10	\$72.00	\$27.00	(\$45.00)
Shaving Procedures				

11300	Shaving epidermal or dermal lesion, single, trunk or extremities, 0.5 cm. or less	\$182.40	\$144.00	(\$38.40)
11301	Shaving epidermal or dermal lesion, single, trunk or extremities, 0.6-1.0 centimeter	\$231.00	\$175.00	(\$56.00)
11305	Shaving epidermal or dermal lesion, single, scalp, neck, hands, feet or genitalia, 0.5 cm. or less	\$182.00	\$151.00	(\$31.00)
11306	Shaving epidermal or dermal lesion, single, scalp, neck, hands, feet or genitalia, 0.6 -1 cm.	\$216.40	\$176.00	(\$40.40)
11310	Shaving single epidermal or dermal lesion, on face, 0.5 cm or less	\$206.00	\$166.00	(\$40.00)
11311	Shaving single epidermal or dermal lesion on face; lesion 0.6 to 1.0 cm	\$237.00	\$198.00	(\$39.00)
11055	Paring or cutting of benign hyperkeratotic lesion (e.g., corn, callous)	\$187.20	\$102.00	(\$85.20)
Excision Procedures				
11400	Excision of benign lesion, except skin tag, 0.5 cm. or less	\$280.80	\$187.00	(\$93.80)
11401	Excision of benign lesion, except skin tag, 0.6-1.0 cm.	\$285.60	\$227.00	(\$58.60)
11402	Excision of benign lesion, except skin tag, 1.1-2.0 cm.	\$386.20	\$251.00	(\$135.20)
11403	Excision of benign lesion, except skin tag, 2.1-3.0 cm.	\$395.60	\$289.00	(\$106.60)
11404	Excision of benign lesion, except skin tag, 3.1-4.0 cm.	\$504.20	\$328.00	(\$176.20)
11420	Excision of benign lesion, except skin tag, on scalp, neck, hands, feet, genitalia, 0.5 cm or less	\$260.00	\$185.00	(\$75.00)
11421	Excision of benign lesion, except skin tag, on scalp, necks, hands, feet, genitalia, 0.6-1 cm	\$351.40	\$232.00	(\$119.40)
11422	Excision of benign lesion, except skin tag, on scalp, neck, hands, feet, genitalia, 1.1-2 cm	\$411.60	\$262.00	(\$149.60)
11426	Excision of benign lesion, except skin tag, on scalp, neck, hands, feet, genitalia, over 4.0 cm	\$844.20	\$482.00	(\$362.20)
11440	Excision of other benign lesion, except skin tag, on face, 0.5 cm or less	\$294.60	\$208.00	(\$86.60)
11441	Excision of other benign lesion, except skin tag, on face, 0.6-1 cm	\$392.20	\$253.00	(\$139.20)
Nail Procedures				
11720	Debridement of nail(s) by any method, one to five	\$62.80	\$49.00	(\$13.80)
11730	Complete or partial avulsion of the nail plate, single (removal of the nail without disruption of the underlying matrix or nailbed)	\$332.80	\$167.00	(\$165.80)
11732	Avulsion of each additional nail plate	\$142.00	\$48.00	(\$94.00)
11740	Puncture of nail to remove hematoma or blood	\$180.80	\$84.00	(\$96.80)
11750	Surgical excision of nail with matrix, removing the nail and the underlying nail bed (e.g., ingrown or deformed nail)	\$438.60	\$234.00	(\$204.60)
Wound Repair Procedures				
12001	Simple suture repair of wound, 2.5 cm. or less	\$693.40	\$137.00	(\$556.40)
12002	Simple suture repair of wound, 2.6 to 7.5 cm.	\$900.00	\$166.00	(\$734.00)
12004	Simple suture repair of wound, 7.6 to 12.5 cm.	\$1,055.80	\$193.00	(\$862.80)
12005	Simple suture repair of wound, 12.6 to 20.0 cm.	\$1,226.60	\$257.00	(\$969.60)
12011	Simple suture repair of wound on face, 2.5 cm. or less	\$841.80	\$163.00	(\$678.80)
Destruction Procedures (Any Method)				

17000	Destruction of benign or premalignant lesions with liquid nitrogen (e.g.. actinic keratoses), first lesion	\$137.80	\$100.00	(\$37.80)
17003	Destruction with liquid nitrogen of benign or premalignant lesions: second through 14th lesion	\$22.20	\$10.00	(\$12.20)
17004	Destruction with liquid nitrogen of each additional lesion over 15	\$303.20	\$243.00	(\$60.20)
17110	Destruction with liquid nitrogen of common or plantar warts, to 14 lesions	\$208.20	\$166.00	(\$42.20)
17111	Destruction with liquid nitrogen of common or plantar warts (15 or more)	\$230.60	\$194.00	(\$36.60)
Injection and/or Arthrocentesis Procedures				
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g.. fingers, toes)	\$163.80	\$79.00	(\$84.80)
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g.. wrist, elbow)	\$171.00	\$80.00	(\$91.00)
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g.. Shoulder, hip, knee)	\$286.00	\$95.00	(\$191.00)
20612	ASPIRATE/INJ GANGLION CYST	195	\$96.00	
96372	Injection – Subcutaneous or Intramuscular	\$52.80	\$21.00	(\$31.80)
Splint / Strapping Procedures				
29580	Strapping, Unna Boot	\$202.00	\$92.00	(\$110.00)
Male Health & Procedures				
54050	Destruction of lesion(s), penis, chemical - podophyllin	\$241.40	\$213.00	(\$28.40)
54056	Destruction of lesion(s), penis, simple, cryosurgery Liquid nitrogen	\$266.80	\$215.00	(\$51.80)
Female Health & Procedures				
56405	Drainage of Abscess (Vulva or Perineal Area)	\$599.00	\$212.00	(\$387.00)
56501	Removal of Vulvar Lesion (All Methods)	\$375.20	\$278.00	(\$97.20)
56605	Vulvar Biopsy (One Lesion)	\$281.20	\$139.00	(\$142.20)
57160	Pessary Insertion (for Pelvic Support or Incontinence)	\$236.00	\$108.00	(\$128.00)
57420	Vaginal Exam with Scope (Colposcopy)	\$449.60	\$194.00	(\$255.60)
57454	Cervical Biopsy and Scraping with Scope (Colposcopy)	\$454.60	\$245.00	(\$209.60)
57456	Cervical Scraping Only with Scope (Colposcopy)	\$539.40	\$220.00	(\$319.40)
58100	Uterine Lining (Endometrial) Biopsy	\$332.00	\$146.00	(\$186.00)
58300	IUD Insertion	\$293.00	\$159.00	(\$134.00)
58301	IUD Removal	\$297.20	\$159.00	(\$138.20)
11981	Insertion of Birth Control Implant	\$381.60	\$147.00	(\$234.60)
11982	Removal of Birth Control Implant	\$475.80	\$160.00	(\$315.80)
11983	Removal and Reinsertion of Birth Control Implant	\$698.20	\$206.00	(\$492.20)
Removal of Foreign Body				
65205	Foreign body removal, eye	\$128.00	\$42.00	(\$86.00)

69200 Foreign body removal, external auditory canal	\$377.20	\$118.00	(\$259.20)
69210 Cerumen removal with spoon	\$127.40	\$70.00	(\$57.40)
69209 Removal impacted cerumen irrigation/lvg unliateral	\$66.00	\$23.00	
30300 Removal of foreign body, intranasal	\$829.00	\$301.00	(\$528.00)
Xrays**			
70100 Mandible	\$111.60	\$77.00	(\$34.60)
70140 Facial bone < 3 views	\$147.40	\$67.00	(\$80.40)
70150 Facial bones ≥ 3 views	\$172.40	\$94.00	(\$78.40)
70160 Nasal bones, 3 or more views	\$134.00	\$80.00	(\$54.00)
70210 Sinuses, paranasal, < 3 views	\$110.00	\$69.00	(\$41.00)
70250 Skull	\$98.20	\$76.00	(\$22.20)
71045 Chest, single view	\$77.60	\$56.00	(\$21.60)
71046 Chest, 2 views	\$141.80	\$70.00	(\$71.80)
71100 Ribs, 2 views	\$109.40	\$76.00	(\$33.40)
72040 C-Spine, 2 views (AP + Lat)	\$140.80	\$82.00	(\$58.80)
72070 T-Spine, 2 views (AP + Lat)	\$102.80	\$69.00	(\$33.80)
72100 L-Spine, (AP + Lat)	\$152.20	\$82.00	(\$70.20)
72170 Pelvis, 1 view	\$113.20	\$60.00	(\$53.20)
72220 Sacrum & Coccyx, 2 views	\$134.00	\$70.00	(\$64.00)
73000 Clavicle, 2 views	\$112.60	\$70.00	(\$42.60)
73030 Shoulder, 2 view or more	\$129.60	\$73.00	(\$56.60)
73060 Humerus, 2 view	\$116.80	\$69.00	(\$47.80)
73070 Elbow, 2 views (AP + Lat)	\$98.80	\$63.00	(\$35.80)
73080 Elbow, 3 or more views	\$129.20	\$70.00	(\$59.20)
73090 Forearm, 2 views (AP + Lat)	\$96.80	\$64.00	(\$32.80)
73100 Wrist, 2 views	\$98.20	\$72.00	(\$26.20)
73110 Wrist, 3 views (PA, Lat, Obl)	\$128.40	\$88.00	(\$40.40)
73120 Hand, 2 views	\$85.60	\$68.00	(\$17.60)
73130 Hand, 3 views (PA, Lat, Obl)	\$125.60	\$79.00	(\$46.60)
73140 Finger, 3 views (PA, Lat, Obl)	\$108.60	\$53.00	(\$55.60)
73502 Hip, unilateral, 2 views	\$142.80	\$98.00	(\$44.80)
73521 Hips, bilateral, 2 view each hip including AP view of Pelvis	\$131.00	\$85.00	(\$46.00)

73552	Femur, 2 views		\$76.00	
73560	Knee, 1 or 2 view	\$119.60	\$73.00	(\$46.60)
73562	Knee, 3 views	\$131.20	\$85.00	(\$46.20)
73565	Bilateral knees, standing AP view, weight bearing	\$132.60	\$85.00	(\$47.60)
73590	Leg, Tibia and Fibula, 2 views	\$110.40	\$69.00	(\$41.40)
73600	Ankle, 2 view	\$94.40	\$69.00	(\$25.40)
73610	Ankle, 3 views (AP, Lat, Obl)	\$116.80	\$77.00	(\$39.80)
73620	Foot, 2 views	\$79.60	\$62.00	(\$17.60)
73630	Foot, 3 views (AP, Lat, Obl)	\$102.00	\$73.00	(\$29.00)
73660	Toes, 2 views	\$112.60	\$64.00	(\$48.60)
74018	Abdomen, KUB 1 view	\$125.20	\$64.00	(\$61.20)
77072	Bone-Age (pedi)		\$55.00	
In-Clinic/In-House Testing				
80305	Urine Drug Test	\$41.40	\$13.00	(\$28.40)
81002	Urinalysis nonauto w/o scope		\$4.00	\$4.00
81025	Urine Pregnancy Test	\$28.80	\$9.00	(\$19.80)
82075	Breath Ethanol	\$61.60	\$30.00	(\$31.60)
82270	Occult Blood Feces	\$21.40	\$5.00	(\$16.40)
82962	Glucose Blood Test by device	\$13.00	\$4.00	(\$9.00)
87804	Flu A and B	\$46.00	\$17.00	(\$29.00)
87880	Rapid Strep	\$46.40	\$17.00	(\$29.40)
86328	COVID-19		\$46.00	\$46.00
84600	Urine Validity (Alcohol)		\$18.00	\$18.00
Other Office Procedures				
93000	EKG (electrocardiogram)	\$68.00	\$21.00	(\$47.00)
94010	Spirometry	\$66.00	\$40.00	(\$26.00)
86580	TB Skin Test (PPD)		\$20.00	
94640	Airway Inhalation Treatment	\$44.80	\$12.00	(\$32.80)
Vaccine Administration				
90472	Immunization Administration (2 or more)	\$21.38	\$25.00	\$3.63
90471	Immunization Administration (single)	\$30.12	\$13.00	(\$17.12)
Pediatric Immunizations				

90700 DTaP (Diphtheria, Tetanus, Pertussis)	\$35.00
90696 DTaP-IPV Combination	\$70.00
90723 DTaP-Hep B-IPV Combination	\$115.00
90698 DTaP-IPV-Hib Combination	\$135.00
90697 DTap-IPV-HIB-Hep B Combination	\$175.00
90713 IPV (Polio)	\$50.00
90633 Hepatitis A - Pedi	\$45.00
90744 Hepatitis B - Pedi	\$35.00
90647 Hib (Hemophilus Influenza B)	\$35.00
90651 HPV 9 (Human Papillomavirus)	\$340.00
90620 Meningococcal B	\$260.00
90619 MCV4 (Meningococcal Meningitis)	\$190.00
90707 MMR (Measles, Mumps, Rubella)	\$105.00
90710 MMRV (MMR, Varicella)	\$305.00
90611 MPOX	\$295.00
90671 PCV 15 Pneumococcal 15-Valent - Pedi	\$255.00
90677 PCV 20 (Pneumococcal Conjugate 20-valent) - Adult/Ped	\$305.00
90732 PPSV23 (Pneumococcal Polysaccharide 23-valent)	\$130.00
90381 Respiratory Syncytial Virus (RSV) Antibody - Pedi	\$610.00
90380 Respiratory Syncytial Virus (RSV) Antibody - Pedi	\$610.00
90678 Respiratory Syncytial Virus (RSV) - Pedi	\$325.00
90680 Rotavirus	\$110.00
90714 Td (Tetanus and Diphtheria)	\$45.00
90715 Tdap (Tetanus, Diphtheria, Pertussis) - Pedi	\$55.00
90658 Influenza 6 months and older	\$25.00
91321 COVID 6m - 11yrs	\$140.00
91322 COVID 12 +	\$155.00

Adult Immunizations

90713 IPV (Polio)	\$50.00
90632 Hepatitis A - Adult	\$95.00
90636 Hepatitis A - Hepatitis B - Adult	\$145.00
90746 Hepatitis B - Adult	\$80.00

90707 MMR (Measles, Mumps, Rubella)	\$105.00
90619 MCV4 (Meningococcal Meningitis)	\$190.00
90715 Tdap (Tetanus, Diphtheria, Pertussis) - Adult	\$55.00
90716 Varicella (Chickenpox)	\$200.00
90658 Influenza 6 months and older)	\$25.00
90662 Influenza PVT 65 yrs +	\$85.00
91322 COVID 12 +	\$155.00
90750 Zoster Recombinant Adjuvanted	\$240.00

***Vaccines (state supplied)**

**State supplied vaccines are not listed and are subject to change based on state availability.*

*Fee for any vaccine administered	\$0.00
DT- Diptheria and Tetanus	\$0.00
DTaP - Tetanus, Diptheria, and Pertussis	\$0.00
Flu - Influenza	\$0.00
Hepatitis A	\$0.00
Hepatitis B	\$0.00
Hib - Haemophilus Influenzae Type-B	\$0.00
HPV Human Papillomavirus	\$0.00
IPV Polio	\$0.00
Kinrix - Diptheria, Pertussis Acellular, Tetanus, and Polio	\$0.00
MCV4 - Meningococcal Disease	\$0.00
Meningococcal B - Serogroup B Meningococcal Disease	\$0.00
MMR - Measles, Mumps, and Rubella	\$0.00
MMRV (ProQuad) - Measles, Mumps, Rubella and Varicella	\$0.00
PCV13 - 13 Types of Pneumococcal Bacteria	\$0.00
Pediarix - Tetanus, Diptheria, Pertussis, Polio and Hepatitis B	\$0.00
Pentacel - Diptheria, Tetanus, Pertussis, Poliomyelitis, & Haemophilus Influenza Type B	\$0.00
PPSV23 - 23 Types of Pneumococcal Bacteria	\$0.00
RotaTeq - Rotavirus	\$0.00
Td - Tetanus and Diptheria	\$0.00
Tdap - Tetanus, Diptheria and Pertussis	\$0.00
Varicella - Chickenpox	\$0.00

Office Medications**Miscellaneous**

****Medications, Supplies, and Materials

Send Out Lab Tests**

Test Num	Test Name	
006049	ABO GROUPING AND RHO	\$42.00
004440	ACTH, PLASMA	\$42.00
144000	ACUTE HEPATITIS	\$48.00
008649	AEROBIC BACTERIAL CU	\$9.00
017319	AFP TETRA	\$74.00
010801	AFP, SERUM, OPEN SPI	\$17.00
002253	AFP, SERUM, TUMOR MA	\$17.00
140285	ALBUMIN/CREATININE R	\$12.00
004354	ALDOSTERONE/RENIN RA	\$63.00
601633	ALLERGEN PROFILE, FO	\$36.00
602640	ALLERGENS W/TOTAL IG	\$174.00
676619	ALLERGENS, ZONE 11	\$162.00
001545	ALT (SGPT)	\$10.00
007054	AMMONIA, PLASMA	\$15.00
027094	AMY+LIPASE	\$14.00
164947	ANA BY IFA RFX TITER	\$13.00
382965	ANA, IFA RFX 11 MARK	\$13.00
340897	ANA, IFA RFX 9 MARK	\$13.00
008003	ANAEROBIC AND AEROBI	\$24.00
008904	ANAEROBIC CULTURE	\$15.00
183111	ANAEROBIC/AEROBIC/GR	\$15.00
004705	ANDROSTENEDIONE LCMS	\$33.00
042077	ANEMIA PROFILE B	\$73.00
164914	ANTI-CCP AB, IGG/IGA	\$13.00
500183	ANTI-MULLERIAN HORMO	\$47.00
520131	ANTI-SMOOTH MUSCLE A	\$66.00
006015	ANTIBODY SCREEN	\$13.00

164920	ANTINUCLEAR AB 11 BY	\$102.00
140889	B-TYPE NATRIURETIC P	\$40.00
322758	BASIC METABOLIC PANE	\$9.00
008169	BETA STREP GP A CULT	\$7.00
010181	BETA-2 MICROGLOBULIN	\$22.00
001214	BILIRUBIN, TOTAL/DIR	\$15.00
008300	BLOOD CULTURE, ROUTI	\$19.00
164119	BOWEL DISORDERS CASC	\$66.00
001040	BUN	\$4.00
086207	C DIFFICILE TOXINS A + B	\$22.00
010108	C-PEPTIDE, SERUM	\$21.00
006627	C-REACTIVE PROTEIN,	\$5.00
480061	CA 125, SERUM (SERIA	\$21.00
002261	CA 19-9	\$21.00
140293	CA 27.29	\$21.00
001016	CALCIUM	\$6.00
004804	CALCIUM, IONIZED, SE	\$14.00
003269	CALCIUM, 24HR URINE	\$7.00
123255	CALPROTECTIN, FECAL	\$189.00
002303	CANCER ANTIGEN (CA)	\$21.00
007419	CARBAMAZEPINE(TEGRET	\$15.00
005009	CBC WITH DIFFERENTIA	\$8.00
505271	CD4/CD8 RATIO PROFIL	\$47.00
002139	CEA	\$35.00
164010	CELIAC AB TTG DGP TI	\$149.00
164047	CELIAC AB TTG TIGA W	\$50.00
165118	CELIAC DISEASE AB SC	\$83.00
001560	CERULOPLASMIN	\$14.00
192555	CHANGE IG PAP TO LB	\$21.00
602988	CHILDHOOD ALLERGY PR	\$114.00
183194	CHLAMYDIA/GC AMPLIFI	\$72.00
002154	CK, TOTAL+ISOENZYMES	\$21.00
253295	CMP14+LP+CBC/D/PLT+R	\$121.00

182949	COLOFIT, OCCULT BLOOD	\$16.00
322000	COMP. METABOLIC PANE	\$11.00
006452	COMPLEMENT C3, SERUM	\$12.00
001834	COMPLEMENT C4, SERUM	\$12.00
001586	COPPER, SERUM OR PLA	\$20.00
004051	CORTISOL	\$17.00
104018	CORTISOL - AM	\$17.00
503725	CORTISONE, SERUM, LC	\$33.00
120816	CREATINE KINASE (CK)	\$12.00
002311	CREATINE KINASE (CK)	\$19.00
001362	CREATINE KINASE, TOTA	\$7.00
001370	CREATININE	\$6.00
003012	CREATININE, 24-HOUR	\$4.00
121251	CYSTATIN C	\$22.00
115188	D-DIMER	\$19.00
004020	DHEA-SULFATE	\$23.00
004100	DHEA, SERUM	\$26.00
007385	DIGOXIN, SERUM	\$14.00
096248	EBV EARLY ANTIGEN AB	\$17.00
096255	EBV VCA/EA AB, IGG	\$36.00
004515	ESTRADIOL	\$28.00
004549	ESTROGENS, TOTAL	\$40.00
017996	ETHANOL, BLOOD	\$21.00
511154	FACTOR V LEIDEN MUTA	\$126.00
004598	FERRITIN	\$14.00
117052	FIBRINOGEN ANTIGEN	\$40.00
002014	FOLATE (FOLIC ACID),	\$15.00
004309	FSH	\$6.00
028480	FSH AND LH	\$12.00
180089	GENITAL MYCOPLASMAS	\$166.00
102277	GEST. DIABETES 1-HR	\$5.00
102004	GESTATIONAL GLUCOSE	\$17.00
101200	GLUCOSE (2 SPEC, WHO	\$9.00

001255	GLUCOSE FASTING AND	\$9.00
001818	GLUCOSE, PLASMA	\$4.00
182352	GRAM STAIN W/SPUTUM	\$8.00
180764	H. PYLORI STOOL AG,	\$31.00
005330	HB SOLU + RFLX FRAC	\$7.00
006510	HBSAG SCREEN	\$5.00
551722	HBV QUANT PCR RFX TO	\$165.00
551610	HBV REAL-TIME PCR, Q	\$165.00
144473	HBV SCREENING AND DI	\$38.00
004416	HCG,BETA SUBUNIT, QN	\$16.00
004556	HCG,BETA SUBUNIT,QUA	\$14.00
140659	HCV ANTIBODY	\$15.00
144050	HCV ANTIBODY RFX TO	\$15.00
550555	HCV GENOTYPE REFLEX	\$258.00
550475	HCV GENOTYPING NON R	\$258.00
550090	HCV RNA BY PCR, QN R	\$88.00
550080	HCV RT-PCR, QUANT (N	\$88.00
550362	HCV RT-PCR, QUANT (N	\$88.00
001453	HEMOGLOBIN A1C	\$10.00
302044	HEMOGLOBIN A1C	\$10.00
006734	HEP A AB, IGM	\$12.00
016881	HEP B CORE AB, IGM	\$12.00
006718	HEP B CORE AB, TOT	\$22.00
006395	HEP B SURFACE AB, QU	\$11.00
322755	HEPATIC FUNCTION PAN	\$8.00
006530	HEPATITIS B SURF AB	\$17.00
550486	HEPATITIS C GENOTYPE	\$258.00
237842	HFP7+2AC	\$24.00
121690	HGB FRACTIONATION CA	\$13.00
121697	HGB SOLUBILITY	\$7.00
031088	HGB+HCT	\$6.00
083935	HIV AB/P24 AG WITH R	\$25.00
083940	HIV 1/2 AB DIFFERENT	\$38.00

083964	HIV-1/HIV-2 QUALITAT	\$72.00
139825	HIV-1/HIV-2 QUALITAT	\$72.00
706994	HOMOCYST(E)INE	\$18.00
507800	HPV APTIMA	\$36.00
507810	HPV GENOTYPES 16/18,	\$55.00
507825	HPV GENOTYPES 16/18,	\$55.00
507805	HPV, APTIMA HIGH 16/	\$36.00
008250	HSV CULTURE AND TYPI	\$34.00
186072	HSV CULTURE WITHOUT	\$34.00
164099	HSV 1 AND 2 AB, IGG	\$41.00
162045	IBD EXPANDED PANEL	\$118.00
122390	IFE AND PE, RANDOM U	\$66.00
001495	IFE AND PE, SERUM	\$89.00
607016	IGE CAT/DOG/HORSE W/	\$18.00
604783	IGE FOOD W/COMPONENT	\$114.00
199330	IGP, APTIMA HPV	\$63.00
199320	IGP, CTNG, RFX APTIM	\$99.00
199300	IGP, RFX APTIMA HPV	\$27.00
193157	IGP, CTNG, APTIMAHPV	\$135.00
W20530	IHC EA ADDL AB STAIN	\$66.00
W20531	IHC EA ADDL AB STAIN	\$66.00
W20532	IHC EA ADDL AB STAIN	\$66.00
W20534	IHC EA ADDL AB STAIN	\$66.00
W20061	IHC 1ST AB STAIN X1	\$66.00
W20062	IHC 1ST AB STAIN X2	\$66.00
W20063	IHC 1ST AB STAIN X3	\$66.00
W20065	IHC 1ST AB STAIN X5	\$66.00
001685	IMMUNOFIXATION, SERU	\$74.00
123034	IMMUNOFIXATION, URIN	\$44.00
001776	IMMUNOGLOBULIN G, QN	\$17.00
002295	IMMUNOGLOBULINS A/E/	\$69.00
164086	INFLAMMATORY BOWEL D	\$52.00
481758	INHERITEST(R)CF / SM	\$694.00

004333	INSULIN	\$12.00
213660	INSULIN AND C-PEPTID	\$33.00
070034	IODINE, SERUM OR PLA	\$49.00
001339	IRON	\$5.00
001321	IRON AND TIBC	\$9.00
716944	LAMOTRIGINE (LAMICTA	\$27.00
001115	LDH	\$7.00
717009	LEAD, BLOOD (PEDIATR	\$13.00
716936	LEVETIRACETAM (KEPPR	\$28.00
001404	LIPASE	\$7.00
303756	LIPID PANEL	\$14.00
120188	LIPOPROTEIN (A)	\$18.00
007708	LITHIUM (ESKALITH(R)	\$7.00
163980	LIVER-KIDNEY MICROSO	\$15.00
004283	LUTEINIZING HORMONE(\$6.00
164226	LYME DISEASE SEROLOG	\$31.00
180025	M GENITALIUM NAA, UR	\$36.00
001537	MAGNESIUM	\$7.00
451927	MATERNIT21 PLUS CORE	\$835.00
096560	MEASLES ANTIBODIES,	\$13.00
058495	MEASLES/MUMPS/RUBELL	\$40.00
004234	METANEPHRINES, FRAC,	\$27.00
706961	METHYLMALONIC ACID,	\$41.00
006650	MITOCHONDRIAL (M2) A	\$26.00
006189	MONONUCLEOSIS TEST,	\$6.00
096552	MUMPS ANTIBODIES, IgG	\$13.00
003079	MYOGLOBIN, URINE	\$20.00
143000	NT-PROBNP	\$40.00
002071	OSMOLALITY	\$7.00
003442	OSMOLALITY, URINE	\$13.00
008623	OVA + PARASITE EXAM	\$27.00
010991	PH, STOOL	\$11.00

007823	PHENOBARBITAL, SERUM	\$16.00
007401	PHENYTOIN (DILANTIN)	\$14.00
001024	PHOSPHORUS	\$5.00
881411	PHYSICIAN READ PAP	\$5.00
001180	POTASSIUM	\$5.00
003186	POTASSIUM, 24 HR URI	\$5.00
144053	PREGNANCY, INITIAL S	\$180.00
004317	PROGESTERONE	\$21.00
500167	PROGESTERONE LCMS, E	\$21.00
004465	PROLACTIN	\$20.00
010322	PROSTATE-SPECIFIC AG	\$19.00
003129	PROT+CREATU (RANDOM)	\$8.00
001487	PROTEIN ELECTRO.,S	\$15.00
225920	PROTEIN ELEC + INTER	\$15.00
003277	PROTEIN TOTAL, QN, 2	\$4.00
005199	PROTHROMBIN TIME (PT	\$19.00
020321	PT AND PTT	\$43.00
015610	PTH, INTACT	\$42.00
005207	PTT, ACTIVATED	\$24.00
182879	QUANTIFERON-TB GOLD	\$60.00
550880	REALTIME ABBOTT	\$122.00
002006	RENIN ACTIVITY, PLAS	\$22.00
005280	RETICULOCYTE COUNT	\$11.00
070104	REVERSE T3, SERUM	\$39.00
164065	RHEUMATOID ARTHRITIS	\$24.00
006502	RHEUMATOID FACTOR (R	\$6.00
550420	RNA, REAL TIME PCR (\$122.00
006072	RPR	\$5.00
012021	RPR QN+TP ABS	\$19.00
012005	RPR, RFX QN RPR/CONF	\$5.00
006197	RUBELLA ANTIBODIES,	\$15.00
005215	SEDIMENTATION RATE-W	\$3.00
081034	SELENIUM, BLOOD	\$77.00

S00001	SENSITIVITY ORGANISM	\$11.00
S00002	SENSITIVITY ORGANISM	\$11.00
S00003	SENSITIVITY ORGANISM	\$11.00
082016	SEX HORM BINDING GLO	\$22.00
012708	SJOGREN'S AB, ANTI-S	\$18.00
001198	SODIUM	\$5.00
013326	SODIUM, URINE	\$9.00
481630	SPINAL MUSCULAR ATRO	\$137.00
182354	SPUTUM CULTURE	\$9.00
008144	STOOL CULTURE	\$32.00
188130	STREP GP B CULTURE	\$7.00
188132	STREP GP B NAA	\$42.00
058925	TESTICULAR FUNCTION	\$89.00
004226	TESTOSTERONE	\$26.00
070195	TESTOSTERONE, FREE+T	\$52.00
144980	TESTOSTERONE, FREE,	\$26.00
081786	TESTOSTERONE, FREE/T	\$52.00
070001	TESTOSTERONE, TOTAL,	\$26.00
140103	TESTOSTERONE, FREE AN	\$52.00
042060	TGAB+THYROGLOBULIN,I	\$16.00
330015	THYROID CASCADE PROF	\$17.00
000620	THYROID PANEL WITH T	\$31.00
006676	THYROID PEROXIDASE (\$15.00
140749	THYROID STIM IMMUNOG	\$57.00
001149	THYROXINE (T4)	\$7.00
001974	THYROXINE (T4) FREE,	\$10.00
001735	THYROXINE BINDING GL	\$15.00
188052	TRICH VAG BY NAA	\$65.00
002188	TRIIODOTHYRONINE (T3	\$15.00
010389	TRIIODOTHYRONINE (T3	\$17.00
140150	TROPONIN T	\$14.00
004259	TSH	\$17.00

224576	TSH+FREE T4	\$27.00
010390	T3FREE	\$17.00
024026	T4 AND TSH	\$24.00
377036	UA/M W/RFLX CULTURE,	\$4.00
008342	UPPER RESPIRATORY CU	\$9.00
045120	URIC A+ESR-WES+ANA+R	\$37.00
001057	URIC ACID	\$5.00
003772	URINALYSIS, COMPLETE	\$4.00
003038	URINALYSIS, ROUTINE	\$3.00
008847	URINE CULTURE, ROUTI	\$9.00
008848	URINE CULTURE, ROUTI	\$9.00
007260	VALPROIC ACID (DEPAK	\$14.00
096776	VARICELLA-ZOSTER AB,	\$13.00
096206	VARICELLA-ZOSTER V A	\$70.00
186031	VIRAL CULTURE,RAPID,	\$36.00
186056	VIRAL CULTURE,RAPID,	\$70.00
017509	VITAMIN A, SERUM	\$20.00
121186	VITAMIN B1 (THIAMINE	\$23.00
001503	VITAMIN B12	\$16.00
123220	VITAMIN B2, WHOLE BL	\$39.00
004655	VITAMIN B6, PLASMA	\$35.00
081950	VITAMIN D, 25-HYDROX	\$30.00
138842	WEST NILE VIRUS ANTI	\$60.00
180901	WET PREP	\$11.00
180919	WET PREP W/ TRICH CU	\$11.00
001800	ZINC, PLASMA OR SERU	\$14.00
070085	17-OH PROGESTERONE L	\$28.00
726778	726778 7+ALC-UNBUND	\$63.00
733692	733692 9+OXYCODONE+C	\$63.00
788180	788180 9+ALC-BUND	\$63.00
788210	788210 10 DRUG-BUND	\$63.00
883002	88300 SURGICAL PATHO	\$63.00
883021	88302 SURGICAL PATHO	\$32.00

883022	88302 SURGICAL PATHO	\$32.00
883024	88302 SURGICAL PATHO	\$32.00
883051	88305 SURG PATH-1ST	\$42.00
883052	88305 SURG PATH-2ND	\$42.00
883053	88305 SURG PATH-3RD	\$42.00
883054	88305 SURG PATH-4TH	\$42.00
883055	88305 SURG PATH-5TH	\$42.00

The above codes and fees define the basic scope of services of the CHW Medical Clinic as recommended by the medical director and approved by the COO, additional codes may be used when medically indicated and financially feasible.

Fee schedule rates were calculated based on the CMS 2025 Q1 National Physician Fee Schedule Non-Facility Price for Galveston, TX rates with a 50% increase (rounded up to nearest whole dollar).

When fee schedule rates were not available in the CMS Fee Schedule, Availity was used with a 50% increase (rounded up to nearest whole dollar).

Lab fees were derived using the CMS 2025 Q1 approved reimbursement allowance rounded up the nearest whole dollar. If the allowance is lower than cost, than fee = cost + 10%.

*State vaccines are provided to CHW at no charge by DSHS; therefore, only an administrative fee is charged.

** Xray fees were based upon CMS 2025 Q1 reimbursement rate + Technical Charge + Nominal Reading Fee - rounded up to the highest whole dollar

***Prices for medications and supplies are based upon costs + 20%

[Back to Agenda](#)



Coastal Health & Wellness

2025 Dental Fee Schedule

Proposed Effective Date: 5/1/2025

CDT CODE	DESCRIPTION	2024 FEE SCHEI	2025 PROPOSED FEE	DIFFERENCE
Diagnostic				
D0120	PERIODIC ORAL EVALUATION - EST PATIENT	\$62.00	\$81.00	\$19.00
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	\$89.00	\$117.00	\$28.00
D0145	ORAL EVAL PT UND 3 YR AGE CNSL W/PRIM CAREGIVER	\$88.00	\$103.00	\$15.00
D0150	COMP ORAL EVALUATION - NEW OR EST PATIENT	\$106.00	\$139.00	\$33.00
D0170	RE-EVALUATION - LIMITED PROBLEM FOCUSED	\$69.00	\$106.00	\$37.00
D0171	RE-EVALUATION POST-OPERATIVE OFFICE VISIT	\$78.00	\$101.00	\$23.00
D0180	COMP PERIODONTAL EVALUATION - NEW OR EST PATIENT	\$101.00	\$146.00	\$45.00
D0190	SCREENING OF A PATIENT	\$10.00	\$121.00	\$111.00
D0191	ASSESSMENT OF A PATIENT	\$101.00	\$117.00	\$16.00
D0210	INTRAORAL COMPREHENSIVE SERIES RADIOGPHIC IMAGES	\$157.00	\$195.00	\$38.00
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	\$35.00	\$45.00	\$10.00
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL IMAGE	\$30.00	\$39.00	\$9.00
D0240	INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE	\$45.00	\$59.00	\$14.00
D0270	BITEWING - SINGLE RADIOGRAPHIC IMAGE	\$34.00	\$44.00	\$10.00
D0272	BITEWINGS - TWO RADIOGRAPHIC IMAGES	\$53.00	\$68.00	\$15.00
D0273	BITEWINGS - THREE RADIOGRAPHIC IMAGES	\$62.00	\$80.00	\$18.00
D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	\$79.00	\$95.00	\$16.00
D0277	VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES	\$125.00	\$143.00	\$18.00
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$138.00	\$169.00	\$31.00
D0350	2D ORAL/FACIAL PHOTOGRAPHIC IMAGES	\$102.00	\$103.00	\$1.00
D0391	INTERPRETATION OF DIAGNOSTIC IMAGE	\$41.00	\$388.00	\$347.00
D0411	RADIOGRAPHIC IMAGE CAPTURE ONLY	\$20.00	\$25.00****	\$5.00
D0412	2-D ORAL/FACIAL PHOTOGRAPHIC IMAGE OBTAINED INTRA-ORALLY OR EXTRA-ORALL	\$20.00	\$98.00	\$78.00
D0460	PULP VITALITY TESTS	\$70.00	\$84.00	\$14.00
D0470	DIAGNOSTIC CASTS	\$146.00	\$194.00	\$48.00

D0601	CARIES RISK ASSESS DOCU FINDING OF LOW RISK	\$10.00	\$10.00***	\$0.00
D0602	CARIES RISK AX AND DOCU WITH A FNDNG OF MOD RISK	\$10.00	\$10.00***	\$0.00
D0603	CARIES RISK AX AND DOCU WITH FNDNG OF HIGH RISK	\$10.00	\$10.00***	\$0.00
D0701	PANORAMIC FILM - IMAGE CAPTURE ONLY	\$140.00	\$168.00	\$28.00
D0703	2-D ORAL/FACIAL FILM - IMAGE CAPTURE ONLY	\$90.00	\$122.00	\$32.00
D0706	INTRAORAL OCCLUSAL FILM - IMAGE CAPTURE ONLY	\$53.00	\$63.00	\$10.00
D0707	INTRAORAL PERIAPICAL FLM - IMAGE CAPTURE ONLY	\$30.00	\$54.00	\$24.00
D0708	INTRAORAL BITEWING - IMAGE CAPTURE ONLY	\$34.00	\$68.00	\$34.00
D0709	INTRAORAL CMPRHNSV SERIES RAD IMAGE CAPT ONLY	\$139.00	\$182.00	\$43.00

Preventive

D1110	PROPHYLAXIS - ADULT	\$108.00	\$140.00	\$32.00
D1120	PROPHYLAXIS - CHILD	\$84.00	\$103.00	\$19.00
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	\$54.00	\$61.00	\$7.00
D1208	TOPICAL APPLICATION OF FLUORIDE EXCL VARNISH	\$39.00	\$59.00	\$20.00
D1320	TOBACCO CNSL CONTROL&PREVENTION ORAL DISEASE	\$58.00	\$106.00	\$48.00
D1321	COUNSEL ADVRSE EFFECTS HI RISK SUBSTNCE ABUSE	\$73.00	\$102.00	\$29.00
D1330	ORAL HYGIENE INSTRUCTIONS	\$95.00	\$81.00	(\$14.00)
D1351	SEALANT - PER TOOTH	\$66.00	\$82.00	\$16.00
D1352	PREV RSN REST MOD HIGH CARIES RISK PT-PERM TOOTH	\$126.00	\$153.00	\$27.00
D1354	INTERIM CARIES ARRESTING MEDICATION APPLICATION	\$75.00	\$116.00	\$41.00
D1355	CARIES PREVENTIVE MEDICAMENT APP - PER TOOTH	\$31.00	\$109.00	\$78.00
D1551	RECMT/REBND BILAT SPACE MAINTAINER MAXILLARY	\$83.00	\$144.00	\$61.00
D1552	RECMT/REBND BILAT SPACE MAINTAINER MANDIBULAR	\$98.00	\$148.00	\$50.00
D1553	RECMT/REBND UNI SPACE MAINTAINER PER QUADRANT	\$97.00	\$153.00	\$56.00
D1556	REMOVAL FIXED UNI SPACE MAINTAINER PER QUADRANT	\$87.00	\$143.00	\$56.00
D1557	REMOVAL FIXED BILAT SPACE MAINTAINER MAXILLARY	\$80.00	\$171.00	\$91.00
D1558	REMOVAL FIXED BILAT SPACE MAINTAINER MANDIBULAR	\$96.00	\$176.00	\$80.00

Restorative

D2140	AMALGAM - ONE SURFACE PRIMARY OR PERMANENT	\$162.00	\$229.00	\$67.00
D2150	AMALGAM - TWO SURFACES PRIMARY OR PERMANENT	\$224.00	\$291.00	\$67.00
D2160	AMALGAM - THREE SURFACES PRIMARY OR PERMANENT	\$221.00	\$351.00	\$130.00
D2161	AMALGAM-FOUR/MORE SURFACES PRIMARY/PERMANENT	\$240.00	\$417.00	\$177.00

D2330	RESIN-BASED COMPOSITE - ONE SURFACE ANTERIOR	\$200.00	\$255.00	\$55.00
D2331	RESIN-BASED COMPOSITE - TWO SURFACES ANTERIOR	\$245.00	\$306.00	\$61.00
D2332	RESIN-BASED COMPOSITE - THREE SURFACES ANTERIOR	\$298.00	\$371.00	\$73.00
D2335	RESIN BASED COMPOSITE 4/> SURFACES ANTERIOR	\$255.00	\$464.00	\$209.00
D2390	RESIN-BASED COMPOSITE CROWN ANTERIOR	\$420.00	\$716.00	\$296.00
D2391	RESIN-BASED COMPOSITE - ONE SURFACE POSTERIOR	\$216.00	\$274.00	\$58.00
D2392	RESIN-BASED COMPOSITE - TWO SURFACES POSTERIOR	\$274.00	\$348.00	\$74.00
D2393	RESIN-BASED COMPOSITE - THREE SURFACES POSTERIOR	\$349.00	\$422.00	\$73.00
D2394	RESIN COMPOS - FOUR OR MORE SURFACES POSTERIOR	\$410.00	\$497.00	\$87.00
D2920	RE-CEMENT OR RE-BOND CROWN	\$125.00	\$179.00	\$54.00
D2921	REATTACHMENT OF TOOTH FRAG INCISAL EDGE/CUSP	\$176.00	\$394.00	\$218.00
D2940	PLACEMENT OF INTERIM DIRECT RESTORATION	\$115.00	\$199.00	\$84.00
D2950	CORE BUILDUP INCLUDING ANY PINS WHEN REQUIRED	\$319.00	\$397.00	\$78.00
D2951	PIN RETENTION - PER TOOTH ADDITION RESTORATION	\$75.00	\$117.00	\$42.00
D2955	POST REMOVAL	\$355.00	\$406.00	\$51.00
D2956	REMOVAL OF AN INDIRECT RESTORATION ON A NATURAL TOOTH		\$150.00**	
D2980	CROWN REPAIR MATERIAL FAILURE	\$250.00	\$415.00	\$165.00
D2983	VENEER REPAIR BY REPORT	\$235.00	\$448.00	\$213.00
D2989	EXCAVATION OF A TOOTH RESULTING IN THE DETERMINATION OF NON-RESTORABILITY		\$331.00**	
Endodontics				
D3110	PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)	\$100.00	\$131.00	\$31.00
D3120	PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)	\$97.00	\$125.00	\$28.00
D3332	INCOMPLETE ENDO TX; INOP UNRESTORABLE/FX TOOTH	\$545.00	\$633.00	\$88.00
D3333	INTERNAL ROOT REPAIR OF PERFORATION DEFECTS	\$0.00	\$507.00	\$507.00
Periodontics				
D4210	GINGIVECT/PLSTY 4/>CNTIG/TOOTH BOUND SPACES-QUAD	\$851.00	\$901.00	\$50.00
D4211	GINGIVECT/PLSTY 1-3 CNTIG/TOOTH BOUND SPACE-QUAD	\$413.00	\$502.00	\$89.00
D4212	GINGIVECT/PLSTY FOR ACCESS RESTORATION PER TOOTH	\$217.00	\$433.00	\$216.00
D4249	CLINICAL CROWN LENGTHENING - HARD TISSUE	\$874.00	\$1,138.00	\$264.00
D4320	PROVISIONAL SPLINTING INTRACORONAL		\$516.00**	
D4322	SPLINT INTRACORONAL NATURAL TEETH OR PROS CROWN	\$516.00	\$735.00	\$219.00
D4323	SPLINT EXTRACORONAL NATURAL TEETH OR PROS CROWN	\$430.00	\$680.00	\$250.00
D4341	PRDONTAL SCALING&ROOT PLANING 4/MORE TEETH-QUAD	\$299.00	\$372.00	\$73.00

D4342	PRDONTAL SCALING&ROOT PLANING 1-3 TEETH-QUAD	\$225.00	\$283.00	\$58.00
D4346	SCALNG GNGIVAL INFLAMM FULL MOUTH AFTR ORAL EVAL	\$219.00	\$246.00	\$27.00
D4355	FULL MOUTH DEBRID ENABLE COMP PERIO EVAL & DX	\$212.00	\$275.00	\$63.00
D4910	PERIODONTAL MAINTENANCE	\$171.00	\$201.00	\$30.00
Prosthodontics Removable				
D5410	ADJUST COMPLETE DENTURE - MAXILLARY	\$106.00	\$137.00	\$31.00
D5411	ADJUST COMPLETE DENTURE - MANDIBULAR	\$104.00	\$137.00	\$33.00
D5421	ADJUST PARTIAL DENTURE - MAXILLARY	\$104.00	\$134.00	\$30.00
D5422	ADJUST PARTIAL DENTURE - MANDIBULAR	\$104.00	\$137.00	\$33.00
D5850	TISSUE CONDITIONING MAXILLARY	\$143.00	\$315.00	\$172.00
D5851	TISSUE CONDITIONING MANDIBULAR	\$173.00	\$316.00	\$143.00
Maxillofacial Prosthetics				
D5986	FLUORIDE GEL CARRIER	\$104.00	\$292.00	\$188.00
Prosthodontics Fixed				
D6930	RECEMENT / REBOND FIXED PARTIAL DENTURE	\$173.00	\$269.00	\$96.00
Oral and Maxillofacial Surgery				
D7111	EXTRACTION CORONAL REMNANTS - PRIMARY TOOTH	\$161.00	\$208.00	\$47.00
D7140	EXTRACTION ERUPTED TOOTH OR EXPOSED ROOT	\$203.00	\$293.00	\$90.00
D7210	EXTRACTION ERUPTED TOOTH REMV BONE ELEV FLAP	\$330.00	\$423.00	\$93.00
D7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	\$390.00	\$466.00	\$76.00
D7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	\$487.00	\$568.00	\$81.00
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	\$348.00	\$455.00	\$107.00
D7261	PRIMARY CLOSURE OF A SINUS PERFORATION	\$784.00	\$1,120.00	\$336.00
D7270	TOOTH REIMPL &/OR STBL ACC EVULSED/DISPLCD TOOTH	\$626.00	\$795.00	\$169.00
D7310	ALVEOLOPLASTY W/EXTRACTION 4/> TEETH/SPACE QUAD	\$335.00	\$461.00	\$126.00
D7311	ALVEOLOPLSTY CONJNC XTRACT 1-3 TEETH/SPACES QUAD	\$416.00	\$451.00	\$35.00
D7320	ALVEOLOPLASTY NOT W/EXTRACTIONS 4/> TEETH/SPACE	\$300.00	\$651.00	\$351.00
D7321	ALVEOLOPLSTY NOT CNJNC XTRCT 1-3 TEETH/SPCE QUAD	\$328.00	\$599.00	\$271.00
D7471	REMOVAL OF LATERAL EXOSTOSIS	\$823.00	\$1,098.00	\$275.00
D7510	INCISION & DRAINAGE ABSCESS-INTRAORAL SOFT TISS	\$162.00	\$361.00	\$199.00
D7910	SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM	\$548.00	\$548.00*	\$0.00
D7961	BUCCAL/LABIAL FRENECTOMY (FRENULECTOMY)	\$495.00	\$644.00	\$149.00

Adjunctive General Services

D9110	PALLIATIVE TREATMENT OF DENTAL PAIN PER VISIT	\$150.00	\$200.00	\$50.00
D9120	FIXED PARTIAL DENTURE SECTIONING	\$250.00	\$324.00	\$74.00
D9210	LOCAL ANES-NOT CONJUNCTION W/OP/SURGICAL PROC	\$15.00	\$108.00	\$93.00
D9310	CONSULT DX SERV DENT/PHY NOT REQUESTING DENT/PHY	\$152.00	\$196.00	\$44.00
D9311	CONSULT WITH MEDICAL HEALTHCARE PROFESSIONAL	\$50.00	\$252.00	\$202.00
D9430	OFFICE VISIT OBSERVATION NO OTHER SRVC PERFORMED	\$100.00	\$120.00	\$20.00
D9440	OFFICE VISIT - AFTER REGULARLY SCHEDULED HOURS	\$213.00	\$266.00	\$53.00
D9450	CASE PRESENTATION AFTER DETL&EXTN TREATMENT PLAN	\$155.00	\$244.00	\$89.00
D9910	APPLICATION OF DESENSITIZING MEDICAMENT	\$36.00	\$90.00	\$54.00
D9911	APPLIC DESENZT RSN CERV &OR ROOT SURF-TOOTH	\$36.00	\$108.00	\$72.00
D9943	OCCLUSAL GUARD ADJUSTMENT	\$119.00	\$188.00	\$69.00
D9950	OCCLUSION ANALYSIS - MOUNTED CASE	\$231.00	\$522.00	\$291.00
D9951	OCCLUSAL ADJUSTMENT - LIMITED	\$184.00	\$273.00	\$89.00
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	\$500.00	\$906.00	\$406.00
D9995	TELEDENTISTRY - SYNCHRONOUS; REAL TIME ENCOUNTER	\$0.00	\$0.00***	\$0.00
D9996	TEL DENTISTRY ASYNCHRONOUS INFO FWD DENTIST SBSQNT REVW	\$0.00	\$0.00***	\$0.00

*No Fee change due to NDAS 2025 < CHW 2024

**New Code

*** Used for billing documentation. Billed with appropriate exam codes for fee capture.

**** Fee not listed in NDAS. 5% Increase with minimum increase \$5.00

The 2025 Proposed Dental Fees were taken from the 80th percentile of the 2025 NDAS with a Geographic multiplier of 0.9776 as supplied by wasserman-medical.com

[Back to Agenda](#)



Coastal Health & Wellness

2025 Dental Contracts Fee Schedule

Proposed Effective Date: 5/1/2025

CDT CODE	DESCRIPTION	2024 FEE SCHEDULE	2025 PROPOSED FEES	DIFFERENCE
Diagnostic				
D1510	space maintainer – fixed unilateral	\$400.00	\$454.00	\$54.00
D1516	space maintainer - fixed - bilateral maxillary	\$513.00	\$591.00	\$78.00
D1517	space maintainer - fixed - bilateral mandibular	\$554.00	\$594.00	\$40.00
D1575	distal shoe space maintainer – fixed – unilateral	\$430.00	\$515.00	\$85.00
Restorative				
D2740	crown - porcelain/ceramic	\$1,400.00	\$1,636.00	\$236.00
D2750	crown - porcelain fused to high noble metal	\$1,375.00	\$1,658.00	\$283.00
D2751	crown - porcelain fused to predominantly base metal	\$1,047.00	\$1,540.00	\$493.00
D2752	crown - porcelain fused to noble metal	\$1,320.00	\$1,570.00	\$250.00
D2790	crown - full cast high noble metal	\$1,421.00	\$1,744.00	\$323.00
D2791	crown - full cast predominantly base metal	\$1,328.00	\$1,542.00	\$214.00
D2792	crown - full cast noble metal	\$1,292.00	\$1,628.00	\$336.00
D2799	interim crown - further treatment or completion of diagnosis necessary prior to final impression	\$536.00	\$631.00	\$95.00
D2928	prefabricated porcelain/ceramic crown – permanent tooth	\$499.00	\$733.00	\$234.00
D2929	prefabricated porcelain/ceramic crown – primary tooth	\$474.00	\$593.00	\$119.00
D2930	prefabricated stainless steel crown - primary tooth	\$312.00	\$388.00	\$76.00
D2931	prefabricated stainless steel crown - permanent tooth	\$370.00	\$471.00	\$101.00
D2932	prefabricated resin crown	\$417.00	\$507.00	\$90.00
D2934	prefab esthetic coated stainless steel crown - primary	\$417.00	\$519.00	\$102.00
D2952	post and core in addition to crown, indirectly fabricated	\$510.00	\$600.00	\$90.00
D2953	each additional indirectly fabricated post – same tooth	\$259.00	\$453.00	\$194.00
D2954	prefabricated post and core in addition to crown	\$400.00	\$489.00	\$89.00
D2971	additional procedures to construct new crown under existing partial denture framework	\$198.00	\$416.00	\$218.00

Endodontics

D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to dentinocemental junction and application of medicament	\$239.00	\$314.00	\$75.00
D3221	pulpal debridement - primary and permanent teeth, not to be used for apexogenesis	\$276.00	\$337.00	\$61.00
D3310	endodontic therapy - anterior tooth (excluding final restoration)	\$1,000.00	\$1,108.00	\$108.00
D3320	endodontic therapy - bicuspid tooth (excluding final restoration)	\$1,122.00	\$1,260.00	\$138.00
D3330	endodontic therapy - molar tooth (excluding final restoration)	\$1,432.00	\$1,524.00	\$92.00
D3346	retreatment of previous root canal therapy - anterior	\$1,250.00	\$1,285.00	\$35.00
D3347	retreatment of previous root canal therapy - bicuspid	\$1,420.00	\$1,425.00	\$5.00
D3348	retreatment of previous root canal therapy - molar	\$1,645.00	\$1,691.00	\$46.00

Prosthodontics Removable

D5110	complete denture - maxillary	\$1,870.00	\$2,720.00	\$850.00
D5120	complete denture - mandibular	\$1,818.00	\$2,737.00	\$919.00
D5130	immediate denture - maxillary	\$1,768.00	\$2,818.00	\$1,050.00
D5140	immediate denture - mandibular	\$1,737.00	\$2,832.00	\$1,095.00
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	\$1,526.00	\$2,102.00	\$576.00
D5212	mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	\$1,429.00	\$2,109.00	\$680.00
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$1,950.00	\$2,737.00	\$787.00
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$1,977.00	\$2,737.00	\$760.00
D5221	immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	\$1,080.00	\$2,211.00	\$1,131.00
D5222	immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	\$1,119.00	\$2,227.00	\$1,108.00
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$2,244.00	\$2,542.00	\$298.00
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$2,244.00	\$2,542.00	\$298.00
D5225	maxillary partial denture - flexible base (including retentive/clasping materials, rests and teeth)	\$1,942.00	\$2,277.00	\$335.00
D5226	mandibular partial denture - flexible base (including retentive/clasping materials, rests and teeth)	\$1,895.00	\$2,285.00	\$390.00

D5227	immediate maxillary partial denture - flexible base (including retentive/clasping materials, rests and teeth)	\$1,717.00	\$2,433.00	\$716.00
D5228	immediate mandibular partial denture - flexible base (including retentive/clasping materials, rests and teeth)	\$1,989.00	\$2,438.00	\$449.00
D5282	removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	\$1,000.00	\$1,680.00	\$680.00
D5283	removable unilateral partial dent – one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	\$1,248.00	\$1,669.00	\$421.00
D5284	removable unilateral partial denture – one piece flex base (including retentive/clasping materials, rests and teeth), per quadrant	\$916.00	\$1,662.00	\$746.00
D5286	remov unil prt dent – 1 piece resin (inc clps/tth) per quad	\$916.00	\$1,662.00	\$746.00
D5511	repair broken complete denture base - mandibular	\$219.00	\$355.00	\$136.00
D5512	repair broken complete denture base - maxillary	\$240.00	\$355.00	\$115.00
D5520	replace missing or broken teeth - complete denture - each tooth	\$190.00	\$298.00	\$108.00
D5611	repair resin partial denture base - mandibular	\$273.00	\$334.00	\$61.00
D5612	repair resin partial denture base - maxillary	\$272.00	\$338.00	\$66.00
D5621	repair cast partial framework mandibular	\$238.00	\$418.00	\$180.00
D5622	repair cast partial framework maxillary	\$264.00	\$422.00	\$158.00
D5630	repair or replace broken retentive clasping materials - per tooth	\$311.00	\$390.00	\$79.00
D5640	replace broken teeth - per tooth	\$205.00	\$295.00	\$90.00
D5650	add tooth to existing partial denture	\$250.00	\$347.00	\$97.00
D5660	add clasp to existing partial denture - per tooth	\$274.00	\$397.00	\$123.00
D5670	replace all teeth on and acrylic on cast metal framework (maxillary)	\$748.00	\$1,056.00	\$308.00
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	\$748.00	\$1,062.00	\$314.00
D5710	rebase complete maxillary denture	\$762.00	\$852.00	\$90.00
D5711	rebase complete mandibular denture	\$723.00	\$845.00	\$122.00
D5720	rebase maxillary partial denture	\$714.00	\$811.00	\$97.00
D5721	rebase mandibular partial denture	\$714.00	\$811.00	\$97.00
D5730	reline complete maxillary denture (direct)	\$439.00	\$563.00	\$124.00
D5731	reline complete mandibular denture (direct)	\$439.00	\$555.00	\$116.00
D5740	reline maxillary partial denture (direct)	\$391.00	\$547.00	\$156.00
D5741	reline mandibular partial denture (direct)	\$395.00	\$546.00	\$151.00
D5750	reline complete maxillary denture (indirect)	\$561.00	\$675.00	\$114.00
D5751	reline complete mandibular denture (indirect)	\$547.00	\$678.00	\$131.00

D5760	reline maxillary partial denture (indirect)	\$518.00	\$668.00	\$150.00
D5761	reline mandibular partial denture (indirect)	\$521.00	\$669.00	\$148.00
D5765	soft liner for comp or prtl removable denture – indirect	\$570.00	\$784.00	\$214.00
D5810	interim complete denture (maxillary)	\$901.00	\$1,330.00	\$429.00
D5811	interim complete denture (mandibular)	\$969.00	\$1,363.00	\$394.00
D5820	interim partial denture (including retentive/clasping materials, rests and teeth), maxillary	\$844.00	\$1,001.00	\$157.00
D5821	interim partial denture (including retentive/clasping materials, rests and teeth), mandibular	\$848.00	\$1,001.00	\$153.00
D5863	overdenture - complete maxillary	\$4,000.00	\$3,219.00	(\$781.00)
D5864	overdenture - partial maxillary	\$2,601.00	\$3,183.00	\$582.00
D5865	overdenture - complete mandibular	\$2,690.00	\$3,226.00	\$536.00
D5866	overdenture - partial mandibular	\$2,703.00	\$3,225.00	\$522.00
D5876	add metal substructure to acrylic full denture (per arch)	\$350.00	\$732.00	\$382.00
D5899	Unspecified removable prosthodontic procedure, by report	\$1,250.00	\$1,500.00	\$250.00
Prosthodontics Fixed				
D6210	pontic – cast high noble metal	\$1,250.00	\$1,616.00	\$366.00
D6240	pontic - porcelain fused to high noble metal	\$1,300.00	\$1,648.00	\$348.00
D6245	pontic - porcelain/ceramic	\$1,367.00	\$1,606.00	\$239.00
D6253	provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	\$903.00	\$995.00	\$92.00
D6545	retainer – cast metal for resin bonded fixed prosthesis	\$828.00	\$1,365.00	\$537.00
D6548	retainer – porcelain/ceramic for resin bonded fixed prosthesis	\$1,236.00	\$1,399.00	\$163.00
D6740	retainer crown - porcelain/ceramic	\$1,400.00	\$1,625.00	\$225.00
D6750	retainer crown - porcelain fused to high noble metal	\$1,300.00	\$1,649.00	\$349.00
D6790	retainer crown - full cast high noble metal	\$1,350.00	\$1,657.00	\$307.00
D6793	provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	\$668.00	\$814.00	\$146.00
Adjunctive General Services				
D9938	fabrication of a custom removable clear plastic temporary aesthetic appliance	\$150.00	\$489.00	\$339.00
D9939	placement of a custom removable clear plastic temporary aesthetic appliance	\$50.00	\$411.00	\$361.00
D9941	fabrication of athletic mouthguard	\$181.00	\$386.00	\$205.00

D9942	repair and/or reline of occlusal guard	\$218.00	\$342.00	\$124.00
D9944	occlusal guard - hard appliance - full arch	\$679.00	\$831.00	\$152.00
D9945	occlusal guard - soft appliance - full arch	\$700.00	\$730.00	\$30.00
D9946	occlusal guard - hard appliance - partial arch	\$650.00	\$754.00	\$104.00

The 2025 Proposed Dental Fees were taken from the 80th percentile of the 2025 NDAS with a Geographic multiplier of 0.9776 as supplied by wasserman-medical.com

[Back to Agenda](#)



Coastal Health & Wellness

2025 Dental Contracts Discount Eligibility Fee Schedule

Proposed Effective Date: 5/1/2025

CDT CODE	DESCRIPTION	Fee	Discount 100	Discount 80	Discount 60	Discount 40	Discount 20	Discount 0
			0% FPG	20% FPG	40% FPG	60% FPG	80% FPG	100% FPG
Diagnostic								
D1510	space maintainer – fixed unilateral	\$454	\$136.20	\$199.76	\$263.32	\$326.88	\$390.44	\$454.00
D1516	space maintainer - fixed - bilateral maxillary	\$591	\$177.30	\$260.04	\$342.78	\$425.52	\$508.26	\$591.00
D1517	space maintainer - fixed - bilateral mandibular	\$594	\$178.20	\$261.36	\$344.52	\$427.68	\$510.84	\$594.00
D1575	distal shoe space maintainer – fixed – unilateral	\$515	\$154.50	\$226.60	\$298.70	\$370.80	\$442.90	\$515.00
Restorative								
D2740	crown - porcelain/ceramic	\$1,636	\$490.80	\$719.84	\$948.88	\$1,177.92	\$1,406.96	\$1,636.00
D2750	crown - porcelain fused to high noble metal	\$1,658	\$497.40	\$729.52	\$961.64	\$1,193.76	\$1,425.88	\$1,658.00
D2751	crown - porcelain fused to predominantly base metal	\$1,540	\$462.00	\$677.60	\$893.20	\$1,108.80	\$1,324.40	\$1,540.00
D2752	crown - porcelain fused to noble metal	\$1,570	\$471.00	\$690.80	\$910.60	\$1,130.40	\$1,350.20	\$1,570.00
D2790	crown - full cast high noble metal	\$1,744	\$523.20	\$767.36	\$1,011.52	\$1,255.68	\$1,499.84	\$1,744.00
D2791	crown - full cast predominantly base metal	\$1,542	\$462.60	\$678.48	\$894.36	\$1,110.24	\$1,326.12	\$1,542.00
D2792	crown - full cast noble metal	\$1,628	\$488.40	\$716.32	\$944.24	\$1,172.16	\$1,400.08	\$1,628.00
D2799	interim crown - further treatment or completion of diagnosis necessary prior to final impression	\$631	\$189.30	\$277.64	\$365.98	\$454.32	\$542.66	\$631.00
D2928	prefabricated porcelain/ceramic crown – permanent tooth	\$733	\$219.90	\$322.52	\$425.14	\$527.76	\$630.38	\$733.00
D2929	prefabricated porcelain/ceramic crown – primary tooth	\$593	\$177.90	\$260.92	\$343.94	\$426.96	\$509.98	\$593.00
D2930	prefabricated stainless steel crown - primary tooth	\$388	\$116.40	\$170.72	\$225.04	\$279.36	\$333.68	\$388.00
D2931	prefabricated stainless steel crown - permanent tooth	\$471	\$141.30	\$207.24	\$273.18	\$339.12	\$405.06	\$471.00
D2932	prefabricated resin crown	\$507	\$152.10	\$223.08	\$294.06	\$365.04	\$436.02	\$507.00
D2934	prefab esthetic coated stainless steel crown - primary	\$519	\$155.70	\$228.36	\$301.02	\$373.68	\$446.34	\$519.00
D2952	post and core in addition to crown, indirectly fabricated	\$600	\$180.00	\$264.00	\$348.00	\$432.00	\$516.00	\$600.00
D2953	each additional indirectly fabricated post – same tooth	\$453	\$135.90	\$199.32	\$262.74	\$326.16	\$389.58	\$453.00
D2954	prefabricated post and core in addition to crown	\$489	\$146.70	\$215.16	\$283.62	\$352.08	\$420.54	\$489.00
D2971	additional procedures to construct new crown under existing partial denture framework	\$416	\$124.80	\$183.04	\$241.28	\$299.52	\$357.76	\$416.00
Endodontics								
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to dentinocemental junction and application of medicament	\$314	\$94.20	\$138.16	\$182.12	\$226.08	\$270.04	\$314.00
D3221	pulpal debridement - primary and permanent teeth, not to be used for apexogenesis	\$337	\$101.10	\$148.28	\$195.46	\$242.64	\$289.82	\$337.00
D3310	endodontic therapy - anterior tooth (excluding final restoration)	\$1,108	\$332.40	\$487.52	\$642.64	\$797.76	\$952.88	\$1,108.00
D3320	endodontic therapy - bicuspid tooth (excluding final restoration)	\$1,260	\$378.00	\$554.40	\$730.80	\$907.20	\$1,083.60	\$1,260.00
D3330	endodontic therapy - molar tooth (excluding final restoration)	\$1,524	\$457.20	\$670.56	\$883.92	\$1,097.28	\$1,310.64	\$1,524.00
D3346	retreatment of previous root canal therapy - anterior	\$1,285	\$385.50	\$565.40	\$745.30	\$925.20	\$1,105.10	\$1,285.00
D3347	retreatment of previous root canal therapy - bicuspid	\$1,425	\$427.50	\$627.00	\$826.50	\$1,026.00	\$1,225.50	\$1,425.00
D3348	retreatment of previous root canal therapy - molar	\$1,691	\$507.30	\$744.04	\$980.78	\$1,217.52	\$1,454.26	\$1,691.00
Prosthodontics Removable								
D5110	complete denture - maxillary	\$2,720	\$816.00	\$1,196.80	\$1,577.60	\$1,958.40	\$2,339.20	\$2,720.00
D5120	complete denture - mandibular	\$2,737	\$821.10	\$1,204.28	\$1,587.46	\$1,970.64	\$2,353.82	\$2,737.00
D5130	immediate denture - maxillary	\$2,818	\$845.40	\$1,239.92	\$1,634.44	\$2,028.96	\$2,423.48	\$2,818.00
D5140	immediate denture - mandibular	\$2,832	\$849.60	\$1,246.08	\$1,642.56	\$2,039.04	\$2,435.52	\$2,832.00
D5211	maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	\$2,102	\$630.60	\$924.88	\$1,219.16	\$1,513.44	\$1,807.72	\$2,102.00
D5212	mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	\$2,109	\$632.70	\$927.96	\$1,223.22	\$1,518.48	\$1,813.74	\$2,109.00
D5213	maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$2,737	\$821.10	\$1,204.28	\$1,587.46	\$1,970.64	\$2,353.82	\$2,737.00



Coastal Health & Wellness

2025 Dental Contracts Discount Eligibility Fee Schedule

Proposed Effective Date: 5/1/2025

CDT CODE	DESCRIPTION	Fee	Discount 100	Discount 80	Discount 60	Discount 40	Discount 20	Discount 0
			0% FPG	20% FPG	40% FPG	60% FPG	80% FPG	100% FPG
D5214	mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$2,737	\$821.10	\$1,204.28	\$1,587.46	\$1,970.64	\$2,353.82	\$2,737.00
D5221	immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth)	\$2,211	\$663.30	\$972.84	\$1,282.38	\$1,591.92	\$1,901.46	\$2,211.00
D5222	immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth)	\$2,227	\$668.10	\$979.88	\$1,291.66	\$1,603.44	\$1,915.22	\$2,227.00
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$2,542	\$762.60	\$1,118.48	\$1,474.36	\$1,830.24	\$2,186.12	\$2,542.00
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$2,542	\$762.60	\$1,118.48	\$1,474.36	\$1,830.24	\$2,186.12	\$2,542.00
D5225	maxillary partial denture - flexible base (including retentive/clasping materials, rests and teeth)	\$2,277	\$683.10	\$1,001.88	\$1,320.66	\$1,639.44	\$1,958.22	\$2,277.00
D5226	mandibular partial denture - flexible base (including retentive/clasping materials, rests and teeth)	\$2,285	\$685.50	\$1,005.40	\$1,325.30	\$1,645.20	\$1,965.10	\$2,285.00
D5227	immediate maxillary partial denture - flexible base (including retentive/clasping materials, rests and teeth)	\$2,433	\$729.90	\$1,070.52	\$1,411.14	\$1,751.76	\$2,092.38	\$2,433.00
D5228	immediate mandibular partial denture - flexible base (including retentive/clasping materials, rests and teeth)	\$2,438	\$731.40	\$1,072.72	\$1,414.04	\$1,755.36	\$2,096.68	\$2,438.00
D5282	removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary	\$1,680	\$504.00	\$739.20	\$974.40	\$1,209.60	\$1,444.80	\$1,680.00
D5283	removable unilateral partial dent – one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular	\$1,669	\$500.70	\$734.36	\$968.02	\$1,201.68	\$1,435.34	\$1,669.00
D5284	removable unilateral partial denture – one piece flex base (including retentive/clasping materials, rests and teeth), per quadrant	\$1,662	\$498.60	\$731.28	\$963.96	\$1,196.64	\$1,429.32	\$1,662.00
D5286	remov unil prtl dent – 1 piece resin (inc clps/tth) per quad	\$1,662	\$498.60	\$731.28	\$963.96	\$1,196.64	\$1,429.32	\$1,662.00
D5511	repair broken complete denture base - mandibular	\$355	\$125.00	\$156.20	\$205.90	\$255.60	\$305.30	\$355.00
D5512	repair broken complete denture base - maxillary	\$355	\$125.00	\$156.20	\$205.90	\$255.60	\$305.30	\$355.00
D5520	replace missing or broken teeth - complete denture - each tooth	\$298	\$95.00	\$131.12	\$172.84	\$214.56	\$256.28	\$298.00
D5611	repair resin partial denture base - mandibular	\$334	\$105.00	\$146.96	\$193.72	\$240.48	\$287.24	\$334.00
D5612	repair resin partial denture base - maxillary	\$338	\$105.00	\$148.72	\$196.04	\$243.36	\$290.68	\$338.00
D5621	repair cast partial framework mandibular	\$418	\$125.40	\$183.92	\$242.44	\$300.96	\$359.48	\$418.00
D5622	repair cast partial framework maxillary	\$422	\$126.60	\$185.68	\$244.76	\$303.84	\$362.92	\$422.00
D5630	repair or replace broken retentive clasping materials - per tooth	\$390	\$117.00	\$171.60	\$226.20	\$280.80	\$335.40	\$390.00
D5640	replace broken teeth - per tooth	\$295	\$95.00	\$95.00	\$118.90	\$147.60	\$176.30	\$205.00
D5650	add tooth to existing partial denture	\$347	\$95.00	\$110.00	\$145.00	\$180.00	\$215.00	\$250.00
D5660	add clasp to existing partial denture - per tooth	\$397	\$119.10	\$174.68	\$230.26	\$285.84	\$341.42	\$397.00
D5670	replace all teeth on and acrylic on cast metal framework (maxillary)	\$1,056	\$316.80	\$464.64	\$612.48	\$760.32	\$908.16	\$1,056.00
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	\$1,062	\$318.60	\$467.28	\$615.96	\$764.64	\$913.32	\$1,062.00
D5710	rebase complete maxillary denture	\$852	\$255.60	\$374.88	\$494.16	\$613.44	\$732.72	\$852.00
D5711	rebase complete mandibular denture	\$845	\$253.50	\$371.80	\$490.10	\$608.40	\$726.70	\$845.00
D5720	rebase maxillary partial denture	\$811	\$243.30	\$356.84	\$470.38	\$583.92	\$697.46	\$811.00
D5721	rebase mandibular partial denture	\$811	\$243.30	\$356.84	\$470.38	\$583.92	\$697.46	\$811.00
D5730	reline complete maxillary denture (direct)	\$563	\$168.90	\$247.72	\$326.54	\$405.36	\$484.18	\$563.00
D5731	reline complete mandibular denture (direct)	\$555	\$166.50	\$244.20	\$321.90	\$399.60	\$477.30	\$555.00
D5740	reline maxillary partial denture (direct)	\$547	\$164.10	\$240.68	\$317.26	\$393.84	\$470.42	\$547.00
D5741	reline mandibular partial denture (direct)	\$546	\$163.80	\$240.24	\$316.68	\$393.12	\$469.56	\$546.00
D5750	reline complete maxillary denture (indirect)	\$675	\$202.50	\$297.00	\$391.50	\$486.00	\$580.50	\$675.00



Coastal Health & Wellness

2025 Dental Contracts Discount Eligibility Fee Schedule

Proposed Effective Date: 5/1/2025

CDT CODE	DESCRIPTION	Fee	Discount 100	Discount 80	Discount 60	Discount 40	Discount 20	Discount 0
			0% FPG	20% FPG	40% FPG	60% FPG	80% FPG	100% FPG
D5751	reline complete mandibular denture (indirect)	\$678	\$203.40	\$298.32	\$393.24	\$488.16	\$583.08	\$678.00
D5760	reline maxillary partial denture (indirect)	\$668	\$200.40	\$293.92	\$387.44	\$480.96	\$574.48	\$668.00
D5761	reline mandibular partial denture (indirect)	\$669	\$200.70	\$294.36	\$388.02	\$481.68	\$575.34	\$669.00
D5765	soft liner for comp or prtl removable denture – indirect	\$784	\$235.20	\$344.96	\$454.72	\$564.48	\$674.24	\$784.00
D5810	interim complete denture (maxillary)	\$1,330	\$399.00	\$585.20	\$771.40	\$957.60	\$1,143.80	\$1,330.00
D5811	interim complete denture (mandibular)	\$1,363	\$408.90	\$599.72	\$790.54	\$981.36	\$1,172.18	\$1,363.00
D5820	interim partial denture (including retentive/clasping materials, rests and teeth), maxillary	\$1,001	\$300.30	\$440.44	\$580.58	\$720.72	\$860.86	\$1,001.00
D5821	interim partial denture (including retentive/clasping materials, rests and teeth), mandibular	\$1,001	\$300.30	\$440.44	\$580.58	\$720.72	\$860.86	\$1,001.00
D5863	overdenture - complete maxillary	\$3,219	\$965.70	\$1,416.36	\$1,867.02	\$2,317.68	\$2,768.34	\$3,219.00
D5864	overdenture - partial maxillary	\$3,183	\$954.90	\$1,400.52	\$1,846.14	\$2,291.76	\$2,737.38	\$3,183.00
D5865	overdenture - complete mandibular	\$3,226	\$967.80	\$1,419.44	\$1,871.08	\$2,322.72	\$2,774.36	\$3,226.00
D5866	overdenture - partial mandibular	\$3,225	\$967.50	\$1,419.00	\$1,870.50	\$2,322.00	\$2,773.50	\$3,225.00
D5876	add metal substructure to acrylic full denture (per arch)	\$732	\$219.60	\$322.08	\$424.56	\$527.04	\$629.52	\$732.00
D5899	Unspecified removable prosthodontic procedure, by report	\$1,500	\$450.00	\$660.00	\$870.00	\$1,080.00	\$1,290.00	\$1,500.00
Prosthodontics Fixed								
D6210	pontic – cast high noble metal	\$1,616	\$484.80	\$711.04	\$937.28	\$1,163.52	\$1,389.76	\$1,616.00
D6240	pontic - porcelain fused to high noble metal	\$1,648	\$494.40	\$725.12	\$955.84	\$1,186.56	\$1,417.28	\$1,648.00
D6245	pontic - porcelain/ceramic	\$1,606	\$481.80	\$706.64	\$931.48	\$1,156.32	\$1,381.16	\$1,606.00
D6253	provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	\$995	\$298.50	\$437.80	\$577.10	\$716.40	\$855.70	\$995.00
D6545	retainer – cast metal for resin bonded fixed prosthesis	\$1,365	\$409.50	\$600.60	\$791.70	\$982.80	\$1,173.90	\$1,365.00
D6548	retainer – porcelain/ceramic for resin bonded fixed prosthesis	\$1,399	\$419.70	\$615.56	\$811.42	\$1,007.28	\$1,203.14	\$1,399.00
D6740	retainer crown - porcelain/ceramic	\$1,625	\$487.50	\$715.00	\$942.50	\$1,170.00	\$1,397.50	\$1,625.00
D6750	retainer crown - porcelain fused to high noble metal	\$1,649	\$494.70	\$725.56	\$956.42	\$1,187.28	\$1,418.14	\$1,649.00
D6790	retainer crown - full cast high noble metal	\$1,657	\$497.10	\$729.08	\$961.06	\$1,193.04	\$1,425.02	\$1,657.00
D6793	provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	\$814	\$244.20	\$358.16	\$472.12	\$586.08	\$700.04	\$814.00
Adjunctive General Services								
D9938	fabrication of a custom removable clear plastic temporary aesthetic appliance	\$489	\$146.70	\$215.16	\$283.62	\$352.08	\$420.54	\$489.00
D9939	placement of a custom removable clear plastic temporary aesthetic appliance	\$411	\$123.30	\$180.84	\$238.38	\$295.92	\$353.46	\$411.00
D9941	fabrication of athletic mouthguard	\$386	\$115.80	\$169.84	\$223.88	\$277.92	\$331.96	\$386.00
D9942	repair and/or reline of occlusal guard	\$342	\$95.92	\$150.48	\$198.36	\$246.24	\$294.12	\$342.00
D9944	occlusal guard - hard appliance - full arch	\$831	\$249.30	\$365.64	\$481.98	\$598.32	\$714.66	\$831.00
D9945	occlusal guard - soft appliance - full arch	\$730	\$219.00	\$321.20	\$423.40	\$525.60	\$627.80	\$730.00
D9946	occlusal guard - hard appliance - partial arch	\$754	\$226.20	\$331.76	\$437.32	\$542.88	\$648.44	\$754.00

[Back to Agenda](#)



COASTAL HEALTH & WELLNESS

GOVERNING BOARD

9850-A.106 Boardroom Emmett F. Lowry Expressway, Texas City

**Governing Board
April 2025
Item #13
Comments from Board Members**

[Back to Agenda](#)