

PRIVATE INSURANCE BILLING

OBJECTIVES

To fulfill the requirements of Section 10025 of the California Welfare and Institutions Code ensuring the State does not reimburse the County for services when the client was entitled to benefits through a third party reimbursement source.

To ensure that all possible reimbursement sources are identified and billed.

To ensure a knowledgeable staff who are aware of all avenues of possible reimbursement.

To provide a mechanism to alert staff to new areas of revenue enhancement in addition to changes in third party reimbursement procedures and/or requirements.

METHODOLOGY

Clinic financial workers are expected to be skilled in the area of client screening. This includes the area of third party reimbursement sources.

Most third party revenue sources have certain forms, requirements, and time constraints that must be adhered to. Financial Workers are expected to be familiar with all of the above and to ensure compliance.

Clinic personnel should be prepared for the potential problems that could arise from pursuing third party benefits. Some clients are reluctant to have their benefit sources contacted for fear of retribution. It is imperative that the financial staff be trained to recognize this potential problem and to call upon therapeutic assistance to allay the clients' fears when necessary.

Private insurance is a source of third party revenue. The insurance could be a group policy purchased through an employer or organization, or an individual policy purchased directly through an insurance company by the insured.

Most insurance companies have a limitation on payment of one year from the date of service.

A copy of the current insurance identification card should be filed in the client's financial folder. However, a copy of the card does not guarantee eligibility, so a client's

PRIVATE INSURANCE BILLING

insurance coverage should always be verified. The eligibility dates as well as coverage information should always be checked. This policy shouldn't apply exclusively to new clients. Established clients may have changed employers, married or divorced, or are no longer covered by the policy that was in effect during their last visit. Before filing any claim, basic items such as the policy name and number, insured's name, dates of coverage, and secondary insurance information should be obtained. Additionally, inpatient providers need to be aware that more and more insurance companies are requiring prior approval when admitting patients, or within 24 hours in emergencies. Failure to obtain these approvals will result in automatic denial.

The insurance industry is comprised of many companies; each with its own policies, rules, and regulations. The benefits available to groups or individuals vary and the definitions for medical exclusions are almost certain to differ among comparable policies. This variability makes it difficult for a billing staff to predict an insurance company's response to a particular claim submission. When setting standards for dealing with payers, a rule of thumb is to contact them directly for certain basic facts regarding claims submission. It will be helpful to record and file the obtained information as well as the name of the person who provided the information for reference. As much as possible, the answers should be obtained from a supervisor or Provider Relations representative to help insure the accuracy of the claim processing information.

POLICY

It is mandated by the State of California that Los Angeles County Department of Mental Health providers bill private insurance companies for services rendered to their beneficiaries. In the event a client does not want their insurance company billed, or refuses to release information, they must accept liability for, and pay full cost of care.

All charges are to be billed within 30 days of service.

Primary Vs. Secondary Coverage

Households with dual incomes often have more than one insurer. It should be determined which is the primary and which is the secondary insurance company. For commercial plans, the subscriber's or insured's insurance company is always primary for the subscriber. In other words, the husband's insurance company is primary for him and the wife's insurance company is primary for her. However, the primary insurance

PRIVATE INSURANCE BILLING

company for any dependents is determined by the insureds' birth dates, the primary insured being the individual whose birthday is first during the year. This is often referred to as the "birthday rule." For example, if the husband's birthday is October 15, 1965 and the wife's birthday is March 1, 1967, the wife's insurance is the primary for the dependents because her birthday is first during the year (year of birth is ignored). Therefore, obtaining a date of birth for both is important.

Generally, the primary insurer will pay the full benefit (allowable less copayment and deductible). The secondary payer or payers providing supplemental coverage will pay an additional amount up to the allowable or contracted rate or the difference between the actual (billed) charge and the amount paid by the primary payer. The total of the combined payments from the primary and secondary payers should not exceed the total billed charges. When an overpayment occurs, the payers should be notified.

Private Pre-Paid Health Care Plan or Health Maintenance Organization

Members of a private prepaid health care plan, e.g., Health Maintenance Organizations (HMO), Prepaid Health Plans (PHP), Managed Care Plans (MCP), Primary Care Physician Plans (PCPP), and Primary Care Case Management (PCCM), must first look to those entities as being responsible for the provision of their mental health services as defined by their contracted benefits. Private prepaid health care plans are capitated plans that have been paid to provide health services and mental health services. These plans allow for treatment of covered services outside the plan, only for "medically necessary" treatment, with prior authorization from the prepaid health care plan or when the client chooses to personally pay for the cost of treatment.

"Medically necessary services" describes an emergent situation requiring immediate treatment. A service is "medically necessary" when it is reasonable and necessary to prevent significant illness or to alleviate severe pain. (W&I Code 14059.5)

If private prepaid health plan members present themselves at a DMH directly operated clinic or contract agency, the members should be advised that their HMO/health care plan is responsible for managing their care and should be referred back to their respective plans. LACDMH directly operated and contracted providers may only provide treatment to HMO members under these guidelines:

PRIVATE INSURANCE BILLING

- The client is willing to pay for the full cost of care. The client is responsible for payment for services he/she solicited and must pay at the time the service is provided. No further treatment is to be provided until each prior visit is paid for.
- When the HMO provides a statement in writing that mental health care is not covered under the health plan or that the member has exhausted his/her mental health care benefits. Once documentation is received, the client may be treated and charged the Uniform Method for Determining Ability to Pay (UMDAP) liability amount. For members who have obtained and exhausted their mental health care benefits from their health plan, once additional benefits are renewed and become available, usually the following January, the consumers are to be referred back to their HMO/PHP.
- The HMO/health care plan is providing authorization for treatment and paying for the full cost of care. When a private prepaid health care plan denies authorization and the consumer chooses to use the services of the Department of Mental Health or their contract providers, the consumer is responsible for the full cost of care.
- In emergency cases when immediate treatment is required. The PHP/HMO should be billed for "medically necessary" treatment provided to a health plan member in an emergent situation.

COLLECTION FOLLOW-UP - The private prepaid health care plan is responsible for payment of the full cost of care for authorized services and emergency treatment rendered to the health plan member, and is to be billed. If routine collection efforts fail to result in payment, directly operated or County contracted provider staff are to employ stronger methods, including, but not limited to, referral to the Treasurer and Tax Collector.

PROCEDURE FOR BILLING

- Authorization, if required, and other necessary information must be obtained from the insurance company prior to billing. In order to ensure that the services provided will be properly billed and accepted by the insurance company, the following may be required: verification of coverage, effective date, limitations and exclusions; information on the company's requirements such as Pre-Treatment Authorization, forms, documentations, coding to be used, etc.

PRIVATE INSURANCE BILLING

- A signed authorization to release benefits and an assignment of benefits must be obtained from each client prior to billing their insurance company. It is recommended that an extended authorization be used, however, the client's signature on a claim form for each admission is acceptable as long as the authorization and assignment are indicated on the form. (See Supplement 1, Insurance Authorization and Assignment of Benefits).
- When submitting a claim to an insurance company, you may use the insurance company's own form or the CMS-1500 (formerly HCFA-1500). Directly operated providers can order the HCFA-1500 or CMS-1500, whichever is available, from Administrative Services Warehouse by calling at (213) 738-4769. Contract providers, if granted authorization by Administrative Services, may also order these forms; otherwise, they can be purchased at stores such as Office Depot or Staples.
- ICD-9-CM diagnostic codes are to be used to describe a client's medical condition.
- The billing amount should always be the full cost of care rate.
- The charge is to be posted to the client fee card or ledger on a daily or weekly basis (at the discretion of the program head). The insurance company is to be billed within the first ten days of the month following the rendering of services.
- Payments must be posted to both the UMDAP fee card and the insurance fee card. Although this is a duplication of effort, it is required, to ensure a client overpayment of the UMDAP liability doesn't occur.
- Follow-up letters are to be sent to the insurance company every thirty days thereafter until a claim is either paid or denied. These follow-up letters are to request a response regarding the disposition of the claim. See Supplement 2.

A phone call may be required in some cases to finally resolve a case. However, this should be the exception, not the rule, as you want written documentation in the financial folder to substantiate denials.

- All questionable denials shall be reviewed with the program head prior to adjusting off the balance.
- The service must have been provided.

PRIVATE INSURANCE BILLING

- The service was provided within the definition of Medical Necessity as provided in the Short Doyle/Medi-Cal Manual for the Rehabilitation Option and Targeted Case Management.
- The service that was delivered must be appropriately identified when claimed.
- The service must be documented in the medical chart.
- Documentation must meet payor requirements.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

Due to confidentiality laws, prior to billing an insurance company for services rendered, you must have the client's permission to release information. Additionally, unless the client has paid their bill in full, they must agree to assign their benefits to the clinic rendering the services if they expect the clinic to process the paperwork.

The most convenient way to meet this requirement is with the Insurance Authorization and Assignment of Benefits because it is valid for an extended period of time. However, should the client refuse to sign this form, the claim form from their insurance company is acceptable if it contains both a release and an assignment. (See Supplement 1).

INSTRUCTIONS FOR COMPLETING THE HCFA-1500 CLAIM FORM

Providers have the option of using six or eight digit dates; however, they should be used consistently throughout the HCFA-1500.

At the top of the page, right side, marked "CARRIER", the name and address of the insurance company where the claim is being sent may be entered.

At the left side, under the bar code, the carrier may be identified as "PRIMARY" or "SECONDARY" insurer. If the claim is to be submitted to the secondary payer, a copy of the EOB (Explanation of Benefit) from the primary insurer will have to be attached.

Item 1 Enter an "X" in the Group Health Plan Box. If client has individual health insurance, mark Other. Mark also client's other existing benefit plans.

PRIVATE INSURANCE BILLING

- Item 1a Enter the insured's subscriber number, (it may be obtained from the insurance I.D. card, or in some cases, it's the insured's social security number). Verify that the I.D. number corresponds to the insured listed in item 4.
- Item 2 Enter the patient's name (last, first, middle).
- Item 3 Enter the patient's date of birth and sex.
- Item 4 Enter the name of the insured or subscriber. Verify that it corresponds to the I.D. number on Item 1a. You may enter "SAME" if patient and insured are the same.
- Item 5 Enter the patient's mailing address and telephone number. First line - street address, second line - City and State, third line - zip code and phone number.
- Item 6 Mark the appropriate box to indicate patient's relationship to the insured if Item 4 was completed.
- Item 7 Enter the insured's address and telephone number if items 4 to 11 are completed. If the same as patient's, enter "SAME".
- Item 8 Enter an "X" in the applicable box or boxes for the patient's marital status and employment/student status.
- Item 9 a-d If Item 11d is marked "YES", enter the other insurance information.
- Item 10 a-c Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in Item 24.
- Item 10d Leave blank.
- Item 11 Enter the insured's group policy number exactly as it appears on the insurance identification card if the policy was issued through an employer or organization. Verify that it corresponds to Items 1a and 4.
- Item 11a Enter the insured's date of birth and sex.

PRIVATE INSURANCE BILLING

- Item 11b Enter the name of the insured's employer or school.
- Item 11c Enter the insured's coverage plan or program.
- Item 11d Mark "YES" if the patient has other insurance benefit. If Yes, complete items 9 a-d.
- Item 12 If the clinic has a "lifetime authorization" in the clinic record, enter "Signature on File". If the patient is physically or mentally unable to sign, an authorized representative may sign for them. If the patient is illiterate or physically handicapped and signs by a mark, a witness must enter their name and address next to the mark. Enter the date.
- Item 13 A signature assigns payments to the clinic. If the clinic has "lifetime authorization" in the clinic record, enter "Signature on File".
- Item 14 Enter the opening date of the episode.
- Item 15 Enter the date you were first consulted for this illness.
- Item 16 Not required unless the claim is for worker's compensation.
- Item 17 Enter the referring physician's name if this visit is to be billed as a consultation
- Item 18 If the services are related to hospitalization, enter the dates of hospital admission and discharge. If the patient has not been discharged, leave the discharge date blank.
- Item 19 Use this area for procedures that require additional information, justification, or an Emergency Certification Statement.
- Item 20 If laboratory work is being charged on this claim, indicate whether or not it was performed in your office and the amount of the claim.
- Item 21 Enter the patient's diagnoses using ICD-9-CM code numbers and code to the highest level of specificity.

PRIVATE INSURANCE BILLING

- Item 22 Leave blank.
- Item 23 If prior authorization was obtained from the insurer, enter the authorization number, otherwise leave blank.
- Item 24A Enter the date for each service. Enter the "from" and "to" dates if there are several identical services.
- Item 24B Enter the appropriate place of service code(s). Identify the location, using a place of service code for each service performed.
- Item 24C Leave blank.
- Item 24D Enter the appropriate procedure codes using CPT or HCPCS.
- Item 24E Enter the diagnosis code reference number(s) from Item 21 corresponding to the date of service and procedure performed.
- Item 24F Enter the charge for each service.
- Item 24G Enter the number of visits.
- Item 24H-J Leave blank.
- Item 24K Enter the PIN of performing/supervising physician.
- Item 25 Enter your Federal Tax I.D. (Employer identification Number).
- Item 26 This is not required. The patient's MIS number may be entered for your own reference.
- Item 27 This generally applies to government claims.
- Item 28 Enter the total of all charges indicated in 24F.
- Item 29 Enter any payment made by the patient or by another insurance company. Failure to indicate payment by the primary insurer may result in claims denial or overpayment by the secondary payer. If nothing has been paid, indicate 0.

PRIVATE INSURANCE BILLING

- Item 30 Leave blank.
- Item 31 Enter the signature of the provider or their representative and the date the form was signed.
- Item 32 Enter the name and address where services were provided. Enter "SAME" if the name and address are the same as the biller entered on Item 33.
- Item 33 Enter the provider's complete address including zip code, and telephone number.

Enter your provider identification number.

INSURANCE FOLLOW-UP LETTER

All clinics are expected to follow-up with insurance companies when a payment is not received within 30 days. This may be done either by phone or in writing.

The attached letter is an example of the information that must be obtained. Clinics may photocopy this letter using their letterhead should they so desire. (See Supplement 2).