ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE **Date Issued 9/22**

CHAPTER Fiscal Management		**CHAPTER** 07	**SECTION** 003	**SUBJECT** 0080
SECTION Reimbursement	**SUBJECT** Insurance: Verification and Coverage, Billing and Refusal to Provide Information			
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I. APPLICATION:

- ☐ SCCCMHA Board
- ☒ SCCCMHA Providers & Subcontractors
- ☒ Direct-Operated Programs
- ☐ Community Agency Contractors
- ☐ Residential Programs
- ☐ Specialized Foster Care

II. PURPOSE STATEMENT:

St. Clair County Community Mental Health Authority (SCCCMHA) shall ensure that all Michigan Department of Health and Human Services (MDHHS) and/or SCCCMHA funded agencies/programs will ensure the appropriate insurance information and data entry are obtained in accordance with the SCCCMHA and third party payer requirements as outlined in procedures below.

All persons seeking to receive services from St. Clair County Community Mental Health Authority (SCCCMHA) or SCCCMHA funded agencies or programs shall be required to apply for any and all insurance coverage to which they may be entitled in accordance with the Michigan Department of Health and Human Services under the Mental Health Code of 1996, Chapter 8.

III. DEFINITIONS:

A. Ability to Pay (ATP): The ability of a responsible party to pay for the cost of services, determined either as a monthly ability to pay, fee per session or 3rd Party Insurance co-pays.

B. Co-Pays – Fixed amount for a covered service, paid by a patient to the provider of service.

C. Insurance Benefits: Payments made in accordance with insurance coverage for the cost of health care services provided to an individual.

D. Insurance Coverage: Any policy, plan, program or fund established or maintained for the purpose of providing for its participants or their dependents behavioral health, physical health, surgical or hospital benefits. Insurance coverage includes, but is not limited to, Medicaid or Medicare; policies, plans, programs or funds maintained by nonprofit hospital service and medical care corporations,

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health maintenance organizations and prudent purchaser organizations; and commercial, union, association, self–funded and administrative service policies, plans, programs and funds.

E. Medicaid: Monies received from the Michigan Department of Health and Human Services (MDHHS) for services to low income individuals for medical and other service needs as specified by the MDHHS.

F. Medicaid Spend Down: The amount that the Michigan Department of Health and Human Services has determined to be a Medicaid recipient's responsibility to pay before Medicaid becomes active.

G. OASIS: Electronic Health Record software that houses the individual's insurance data and other information related to services provided.

H. Third Party Insurances: Aetna, Blue Cross Blue Shield, HAP, Priority Health, Medicare, etc., that have psychiatric and substance abuse outpatient coverage.

I. Veterans Affairs (VA): VA health care is a benefit and is not considered a health insurance. Veterans Affairs confirms a Veteran's eligibility to receive care at St. Clair County Community Mental Health. Veterans must receive approval from the VA prior to obtaining services. Veteran or a VA staff member schedules an initial appointment with St. Clair County Community Mental Health.

IV. STANDARDS:

A. The decision to enter a zero payment from an insurance company shall be made by the billing account clerk when the insurance company should not have been billed due to incorrect information in OASIS.

B. The decision to pursue collections shall be made by the Chief Executive Officer/designee when the responsible party willfully fails to provide relevant insurance coverage information or fails to complete the appropriate insurance form timely.

C. Pursuant to Section 330.1814 of the Mental Health Code staff will ensure that individuals receiving services apply for all insurance benefits available to them, as applicable.

D. Staff shall inform individuals or responsible parties that any person who fails to apply for or provide information regarding benefits for which they are eligible shall be deemed to have an ability to pay that includes the amount of insurance benefits that would otherwise have been available. If the amount of insurance benefit is not known, the responsible party's ability to pay shall be determined to be the full cost of services.

E. All Non-Medicaid/Non-Healthy Michigan Plan (HMP) Individuals whose income is below the threshold established by MDHHS must apply for Medicaid/HMP (unless the individual has a 3rd party insurance and agrees to pay co-pays). Those Individuals with income exceeding the MDHHS threshold will not be required to apply for Medicaid/HMP. If at any time there is a change in

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circumstances, it is expected that the Individual will apply for Medicaid/HMP at that time.

F. Provider will ensure Substance Use Disorder (SUD) individuals served be held harmless from balance billing of unauthorized services and that individuals served are not held liable when the Prepaid Inpatient Health Plan (PIHP) does not pay the Provider furnishing services under this contract.

V. PROCEDURES:

A. Initial Process & Periodic Review

Account Clerk – Financial Payment and Payment Agreement (FIPA) Tech

1. Receives insurance information from the Region 10 PIHP Access Center upon referral of new individual with third party insurance to include the insurance payer name, benefits phone number and policy ID number.

    a. Verifies insurance information
    b. Enters third party insurance payer in OASIS including effective date, insurance payer name, Policy (ID) and group number. Enter corresponding notes in comment box of the payer screen in OASIS, to include insurance phone number, representative name, date of call, prior authorization requirements, required staff credentials, and co-pay.

2. Meets with or calls individual during intake to collect and review all insurance information. Enters a self-pay payer in OASIS. Obtain photocopies of all insurance cards, front and back, for electronic health record. Reviews all information on insurance card(s), and compares to information in OASIS.

3. Attaches Medicaid eligibility report as verification of coverage and verifies Medicaid coverage monthly with the Medicaid Changes report.

4. Provides assistance or information to complete Assistance Application and Health Care Coverage, if individual does not have Medicaid/HMP and may qualify based on current Annual Income Limit Chart.

5. Notifies individual or responsible party that willful failure to provide relevant insurance coverage information to SCCCMHA or SCCCMHA funded agencies/programs, or if a responsible party willfully fails to apply to have insurance benefits that cover the cost of services provided to the individual, the individual or responsible party's ability to pay shall be determined to include the amount of insurance benefits that would have been available had the insurance benefits been obtained.

    a. In the previously described case, if the amount of insurance benefit is not known, the responsible party's ability to pay shall be determined to be the full cost of services.

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6. Notifies Central Intake Unit (CIU) supervisor and/or clinician/case holder of third party insurance, prior authorization requirements, required staff credentials, co-pay and telepsychiatry benefit.

Primary Case Holder

7. Provides necessary information to the Medical Health Plan (MHP) or insurance carrier to obtain prior authorization, if required. Authorization number and letter are given to billing account clerks.

Account Clerk – Billing

8. Enters authorization numbers in OASIS.

9. Receives Veterans Affairs (VA) information from St. Clair County CMH's Veterans Navigator and/or the Region 10 PIHP Access Center upon referral of new individual with VA benefits.

    a. Enter VA information in OASIS including effective date, ID number, authorization number and number of authorized visits. Enter corresponding notes in the comment box of the payer screen in OASIS to include required staff credentials.

Primary Case Holder/Designee

10. Assists the billing department in obtaining essential information/papers when necessary.

11. Completes the following steps according to insurance coverage:

    a. Medicaid Spend Down

        (1) Is informed by FIPA Tech if individual has a spend down.
        (2) Generate a Medicaid Deductible Monthly Account Invoice from OASIS as soon as individual meets their spend down or completes a hand written Spend Down Report (DHHS-114A) after each service. A copy is to be forwarded to MDHHS.
        (3) Sends MDHHS Health Care Coverage Determination Notice (Form DHS-1606) to account clerk/FIPA Tech and makes a copy for individual's EHR, upon receipt.

Account Clerk-FIPA Tech

12. Reviews 3rd party insurance coverage(s) annually with responsible party by using an electronic eligibility system or phone call to the insurance company.

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Account Clerk - Billing

13. Submits claims to payer(s).

14. Enters all receipts/remittances in OASIS.

15. Reviews status of rejections and/or non-payment of claims monthly and makes adjustments in OASIS. Resubmits rejected or returned claim(s) after taking the suggested action from the insurance company, if appropriate.

16. Notifies subscribers, in writing, of monies owed to SCCCMHA due to insurance company remitting payment to subscriber. Payment is due in full within 14 days.

17. Notifies subscriber/supervisor/primary case holder of necessary information/papers needed to complete/facilitate claim processing.

B. **Collection and Write-Off Procedures**

Account Clerk - Billing

1. Checks open invoices for non-payments in a timely manner. Contacts the insurance company for status inquiry until open invoices are paid.

2. Notifies both the program supervisor and primary case holder if non-payment is the result of not following the primary payer's rules (i.e. LLPC services are not paid but LMSW services are paid).

3. Processes the billing upon receipt of paperwork.

4. Bills individual/Responsible Party for full cost of service for 3 months. If no response after 3 months, offers an installment payment agreement - Outpatient (Form #004), Specialized Residential (Form #002), Hospital Inpatient (Form #002-A) - if individual does not provide insurance information to process a claim.

5. Enters a payment against outstanding insurance invoice upon receipt of payment.

6. Sends a series of three (3) collection letters if no response received after three monthly individual invoices are mailed.

7. Prepares "Request to Send Responsible Party to the Credit Bureau or Write-Off Account" form (Form #264) with applicable documentation for write-off and/or collections (Credit Bureau).

Chief Financial Officer

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8. Approves/disapproves write off required and returns form to the designee.

Chief Executive Officer/Program Director, SCCCMHA Programs/Chief Financial Officer

9. Approves/disapproves and signs the request to send to collections and returns form to the collection designee.

Account Clerk - Billing

10. Adjusts accounts in OASIS upon receiving approval from the Chief Executive Director/designee, Program Director, and the Chief Financial Officer.

11. Tracks collection from the Credit Bureau Services of Michigan.

C. **Overpayments**

Account Clerk – Billing

1. Reviews and submits refund request to the Chief Financial Officer/designee, for approval for overpayment by third party payer.

2. Refunds overpayment.

VI. EXHIBITS:

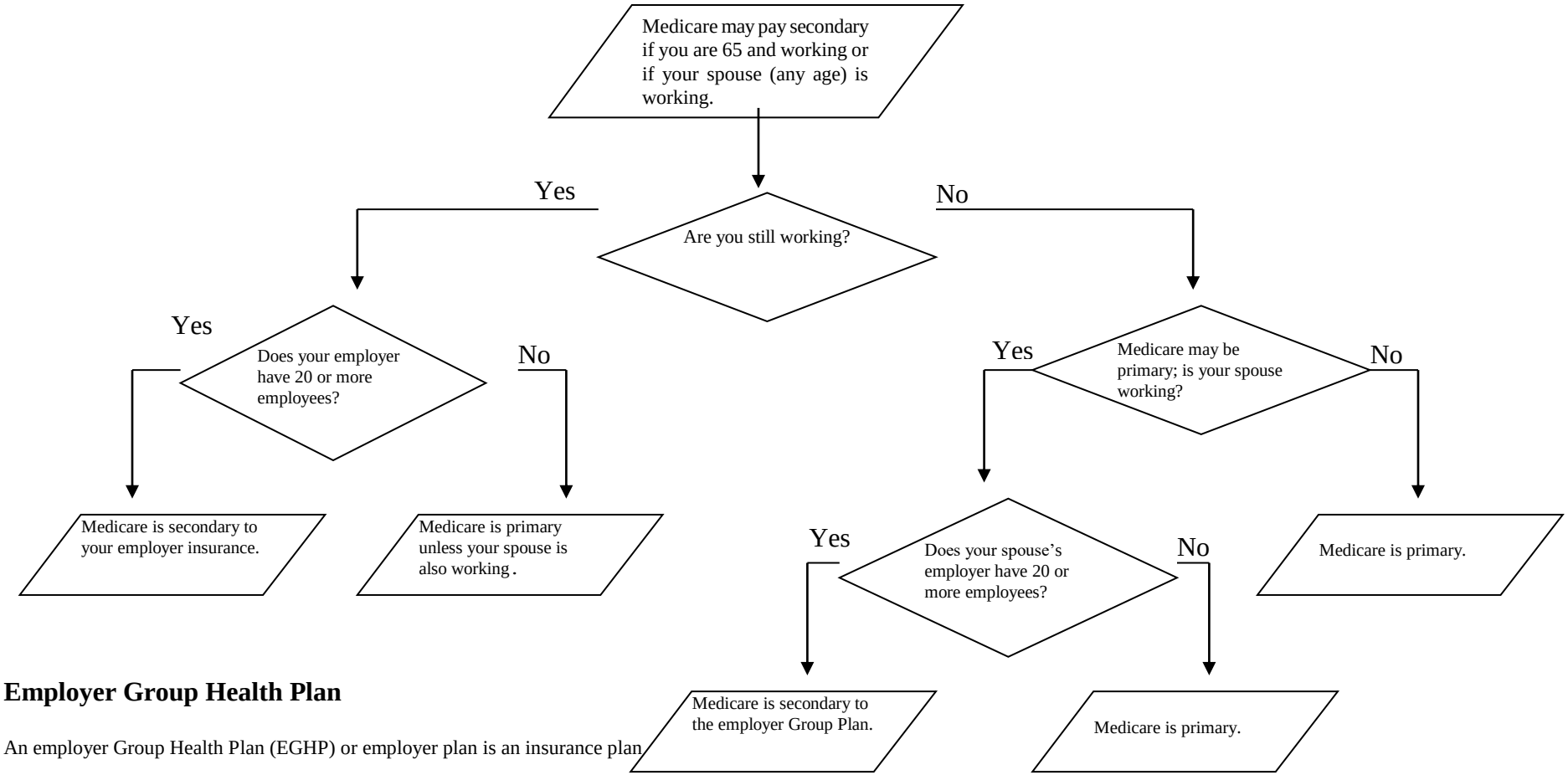
A. Medicare Working Aged Information

B. Medicare Secondary Information for Disabled Beneficiaries

VIII. REVISION HISTORY:

Dates issued 8/21, 9/20, 9/22.

MEDICARE WORKING AGED INFORMATION **EXHIBIT A**



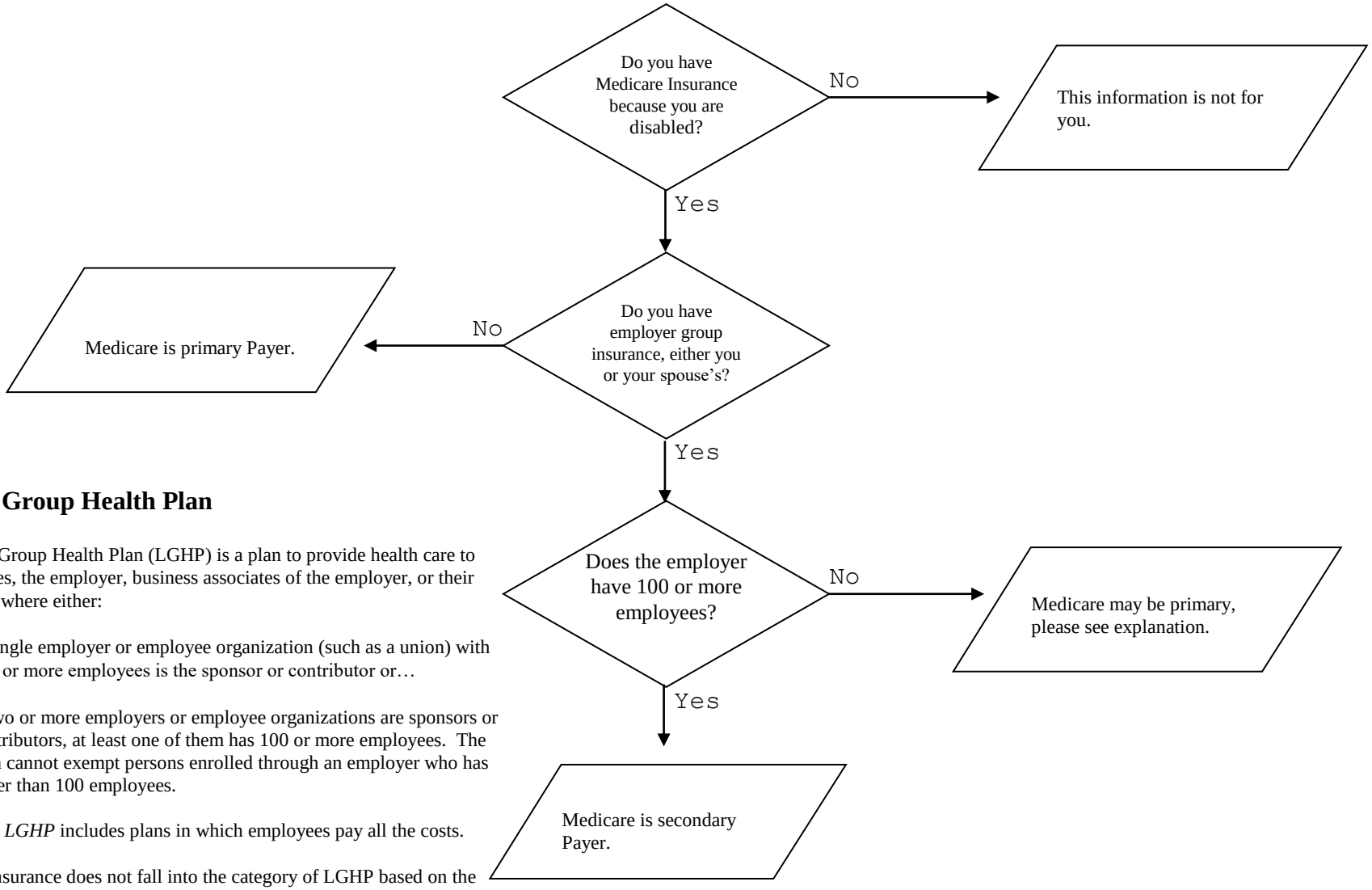
Employer Group Health Plan

An employer Group Health Plan (EGHP) or employer plan is an insurance plan that consists of, or is contributed to, by an employer of 20 or more employees. This plan provides medical care, directly or through other methods, such as insurance or reimbursement to current or former employees and their families.

This includes a multi-employer group health plan that has at least one employer with 20 or more employees. These plans may identify members whose employers have fewer than 20 employees. Such members and their spouses are considered not to meet the conditions for MSP coverage.

If you are still unsure whether Medicare is primary or secondary, or if you need additional help, please call the Customer Service Inquire Department at 1-800-633-4227.

MEDICARE SECONDARY INFORMATION FOR DISABLED BENEFICIARIES **EXHIBIT B**



Large Group Health Plan

A Large Group Health Plan (LGHP) is a plan to provide health care to employees, the employer, business associates of the employer, or their families, where either:

© A single employer or employee organization (such as a union) with 100 or more employees is the sponsor or contributor or…

© If two or more employers or employee organizations are sponsors or contributors, at least one of them has 100 or more employees. The plan cannot exempt persons enrolled through an employer who has fewer than 100 employees.

The term *LGHP* includes plans in which employees pay all the costs.

If your insurance does not fall into the category of LGHP based on the above description, Medicare is your primary insurance.

If you are still unsure whether Medicare is primary or secondary, or if you need additional help, please call the Customer Service Inquiry Department at 1-800-633-4227.