**PROGRAM OPERATIONS DIRECTIVE**
**54.0**

**SUBJECT**: Procedure for Handling Service Requests Not Covered by Insurance

**ISSUED**: 10/21/2025

**PURPOSE:**
To put into immediate effect the procedure for handling service requests not covered by insurance.

**POPULATION:**
All individuals seeking service(s) that are not covered by their current insurance plan. Intake Staff, Primary Case Manager and Financial Information and Payment Agreement Technician (FIPA Tech).

**DIRECTION:**
EFFECTIVE IMMEDIATELY: The purpose of the Administrative Directive is to implement and ensure Individuals requesting services not covered by their insurance are provided with clear and transparent information about the expected cost of services through the Fee Determination and the Advance Beneficiary Notice of Non-Coverage (ABN) process, along with available financial assistance options, including the SCCCMH Sliding Fee Scale (SFS).

**PROCEDURE:**

1. **Service Request Identification**
   - **Responsible Staff:** Intake Staff or Primary Case Holder
   - **Action:**
     - Identify when an Individual requests or is recommended a service that is not covered under their insurance policy. If not sure, contact a FIPA Tech or the Billing Department.
     - Complete the ABN Form with Individual Name, Case Number, and Date. Check service(s) being recommended in Box A. **DO NOT authorize service until the ABN is completed with Option 1 checked and signed by the Individual/Responsible Party.**
2. **Referral to FIPA Tech**
   - **Responsible Staff:** Intake Staff or Primary Case Holder
   - **Action:**
     - Connect the individual with the FIPA Tech (can be in person, via phone, or telehealth depending on availability).
     - Provide ABN form to FIPA Tech.
3. **FIPA Tech Consultation**
   - **Responsible Staff:** FIPA Tech
   - **Action:**
     - Review the requested service on the ABN Form.
     - Notify Individual of financial documentation needed to be assessed on the Sliding Fee Scale.
       - Inform Individual that they must provide their Financial Documentation to be assessed on the Sliding Fee Scale to receive the requested / recommended services.

4. **Fee Determination, Sliding Fee Scale (SFS) and Advance Beneficiary Notice of Non-Coverage (ABN Form)**
    - **Responsible Staff:** FIPA Tech
    - **Action:**
        - Collect necessary income documentation as required by SCCCMH's Sliding Fee Scale policy (e.g., pay stubs, tax return, proof of government assistance).
        - Complete the Fee Determination determining the fee per session and/or monthly maximum in OASIS.
        - Complete Section C of the ABN Form. Have the Responsible Party select Option 1 or Option 2 of the ABN Form.
        - Obtain signed acknowledgment from the individual confirming:
            - They understand the service is not covered by insurance.
            - They are responsible for the indicated cost up to the Monthly Maximum Liability.
        - Notify Intake Staff and/or Primary Case Manager of outcome of Fee Determination and ABN Form once finalized and confirm if the Individual/Responsible Party agreed to payment/sliding fee for the requested service.
5. **Add Services to IPOS and Authorize if Individual/Responsible Party agreed to assessed Fee and signed ABN form**
    - **Responsible Staff:** Intake Staff or Primary Case Holder
    - **Action:**
        - Once Intake Staff and/or Primary Case Holder receives confirmation from a FIPA Tech that the individual agreed to payment and signed ABN (Option 1), then services may be added to IPOS and Authorizations may be added.
        - If Intake Staff and/or Primary Case Holder is notified that the individual does not agree to payment terms (Option 2), the Intake Staff and/or Primary Case Holder **WILL NOT AUTHORIZE** the requested services to plan.
6. **Payment Options Discussion**
    - **Responsible Staff:** Billing Tech
    - **Action:**
        - Discuss available payment options when applicable (e.g., payment plans, upfront payment, recurring billing).
        - Provide assistance in completing any necessary paperwork for installment payment plan agreement.

**Review Cycle**

- This procedure requires annual review or whenever there is a change to insurance coverage.

St. Clair County Community Mental Health

# Advance Beneficiary Notice of Non-Coverage (ABN)

Individual: _____ Case #: _____ Date: _____

**Important:** If your insurance does not cover the services listed below in **Section A**, you may be responsible for the cost of the service. Your insurance may deny coverage for these services even if your health care provider considers them medically necessary based on diagnosis.

| A. Services Not Covered by Insurance | B. Reason Insurance May Not Pay | C. Estimated Cost per Service (based on Sliding Fee Scale) |
|---|---|---|
| ☐ **90791 Intake Assessment** $348.31 per session | Not a Covered Service | |
| ☐ **T1017 Targeted Case Management** $158.28 per 15 mins | | |
| ☐ **H0038 Peer Support Services** $76.80 per 15 mins | | |
| ☐ **T1002 Nursing Services** $69.49 up to 15 mins | | |
| ☐ **Other:** | | |

**Total Monthly Maximum Liability:** $_____

**After reviewing the information above, please choose an option below regarding your decision about your care.**

**Please select ONE option.** Only you can make this selection – *we cannot choose for you.*

- ◯ **Option 1** - I want the service(s) listed in **"Section A."** I understand that I will be responsible for payment and may be asked to pay at the time services are provided.
- ◯ **Option 2** - I do **NOT** want the service(s) listed in **"Section A."** I understand that by making this choice, I **will not** receive the listed service(s) and will therefore not be responsible for payment.

**Additional Information:**

This notice reflects SCCCMH's estimate of your insurance coverage. It is **not** an official denial from your insurance company. If you have any questions, please contact your caseholder **before signing.**

Fees may be ***waived*** if you qualify for Medicaid or ***reduced*** if your household income changes.

_____ _____ _____

Individual/Responsible Party Signature | Print Name | Date

**Attn Caseholders:** For requests to modify existing authorizations, refer to Page 2 for required actions **before submitting this form.**

| Additional Notes: |
|---|
| |



Finance Form: #07-0275
Revised Date: 10/16/2025
Policy Ref: #02-001-0025
EHR: Administrative/Financial, Insurance Policies/Funding Sources *Attach to Self Pay Policy as Supporting Documentation

## EXISTING CASES ONLY

In the event of a change in services for this individual (e.g., the individual selections Option 1 to agree to services, or Option 2 to decline services), **the Caseholder must complete the following steps** to ensure the individual's choices are accurately reflected in the record:

- ☐ Update Authorization(s)
- ☐ Generate an Amendment
- ☐ Generate an Adverse Benefit Determination Notice (ABD)

| _____ | _____ | _____ |
|---|---|---|
| Caseholder Signature/Credentials | Print Name | Date |

**Supervisor Review:**

I have reviewed the individual's record and confirm that all necessary tasks have been completed.

| _____ | _____ | _____ |
|---|---|---|
| Supervisor Signature/Credentials | Print Name | Date |



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