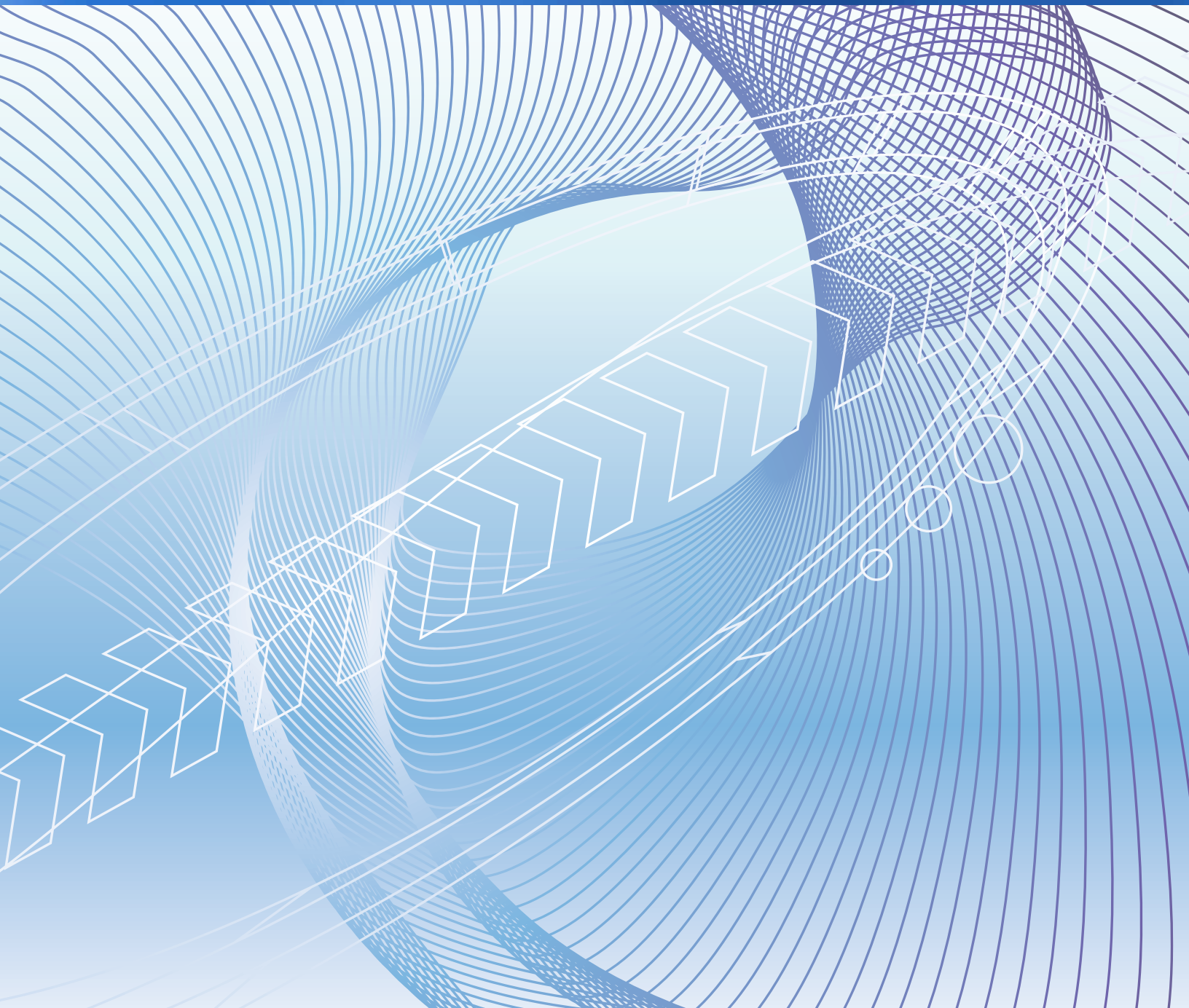




The NIATx Third-party Billing Guide
Second Edition



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Introduction

Parity legislation was signed into law in 2008 and healthcare reform in 2010, and the two are converging now to profoundly affect addiction treatment. By 2014, many more people will have health insurance that covers addiction treatment. Recent estimates show that 30 million of the 45 million people who currently lack insurance soon will have insurance with parity for addiction treatment.

Addiction treatment agencies will not only have many more potential clients. They will also have to shift from relying on grants to billing payers for their services. According to the 2008 National Survey of Substance Abuse Treatment Services (N-SSATS), 35 percent of treatment providers have no capacity to bill insurance for care. Only 53 percent of agencies nationwide can bill Medicaid, and fewer than half have a contract with at least one third-party payer.

The NIATx Third-party Billing Guide, Second Edition, is intended to help agencies make the transition to billing for their services. It provides step-by-step help for agencies with no third-party billing capacity. For agencies that have some or even extensive experience with billing, the guide gives suggestions for improving collections and strengthening the business practices that are essential to stability and growth.

Terms in bold throughout the text are defined in a glossary at the end of the guide. We've also included an appendix with samples of forms you are required to use when billing third-party payers (HCFA, UB-04, CMS 1500). You'll also find sample forms that you can adapt for your organization as you set up your system for working with third-party payers.

We hope that you will find *The NIATx Third-party Billing Guide, Second Edition*, to be a useful tool in creating or improving your system for billing third-party payers.

Before You Get Started

Apply for your National Provider Identifier (NPI) number!

The NPI is a 10-digit number that all substance abuse treatment facilities must have in order to bill third-party payers. Your organization must have its own NPI number, and each staff member who delivers services must also have an NPI number. For more information, visit: <https://www.cms.gov/nationalprovidentstand/>

To apply for your NPI online, visit:

<https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions>

Obtain forms required for billing third-party payers.

When you bill third-party payers, you need to use standard forms: the CMS 1500, the HCFA 1500, or the UB-04. Commercial payers and Medicaid use these standard forms.

Completing these forms properly will help ensure that you receive payment. A third-party payer may deny a claim if the form has missing or incorrect information. A missing birth date or social security number could result in an immediate denial of the claim.

As you establish contracts with more third-party payers, you will find that each payer will have slightly different rules for completing the required forms. Increasingly, third-party payers require that you submit the forms electronically.

The National Uniform Claim Committee (NUCC) developed the CMS 1500 form. You can view a sample of the form as well as instructions on how to complete it at:

<http://www.cms.gov/CMSForms/CMSForms/itemdetail.asp?itemID=CMS1188854>

The UB-04 Institutional Claim Form is the standard form used for billing hospital-based and residential services. It is also known as the CMS-1450 form. The National Uniform Billing Committee (NUBC), part of the American Hospital Association, developed this form over a period of several years. It has now become the institutional claim standard.

For more information, visit the NUBC website: <http://www.nubc.org/index.html>

The required forms are available online at the sites listed above. You can also purchase paper forms through office supply stores.

We've included sample copies of the forms for your reference in the Appendix.

Part I: A Pilot Test

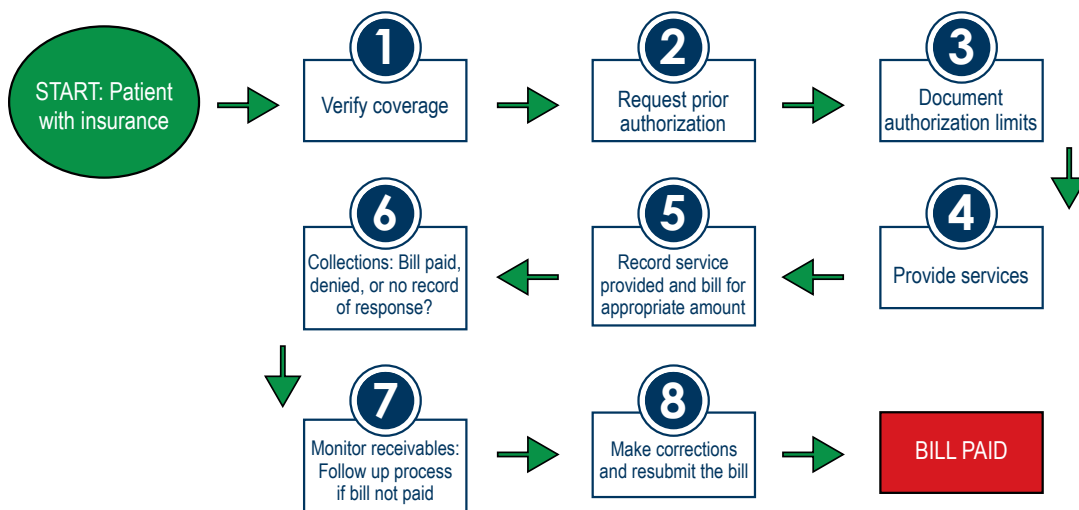
In a grants-based reimbursement system, the revenue side of the balance sheet is fairly constant. You can expect payment based on your contract or grant agreement (except when government payments are late due to budget negotiations or government process issues). Making the transition to billing for services will change your organization. You'll need to dedicate more time and attention to the business practice of fee-for-service billing: verifying coverage, obtaining authorization for services, setting up policies and procedures for accounting, collections, and compliance with payer requirements.

While different business processes and work flows will be required, the new billing environment will create new opportunities and allow you to diversify your revenue stream. As providers like St. Christopher's Inn in New York (<http://www.niatx.net/toolkits/provider/StChristophersInnIncreasingAdmissions.pdf>) and Prairie Ridge in Iowa (<http://www.niatx.net/Story/StoryDetails.aspx?id=285>) have found, adding new payers increases financial stability and creates growth opportunities—even during difficult economic times when some organizations may be reducing services.

While you look for new ways to generate revenue, you will most likely continue to provide care to those who lack insurance or the ability to self-pay. A benefit of working with third-party payers? The fees that you will be collecting can stabilize your income flow, making it easier to provide charity care.

What happens when a client who has insurance comes to your agency? Let's find out with the simple pilot test that follows.

Steps to the Billing Process Covered in the Pilot Test



1. Verify coverage

You probably already gather information from clients at first contact. Your “pilot tester” can add another question to the process: Do you have insurance? Your pilot tester should ask the next client that says “yes” to bring their insurance card to their first appointment.

All insurance cards include a phone number to call for benefits information. Have the person you have assigned the task of this pilot test call the number and request benefit information.

Gather and document the client’s insurance benefits. Make a note of questions or information the insurance company requests regarding the client’s treatment.

2. Request prior authorization

Your client may be enrolled in a **Preferred Provider Organization (PPO)**, or a **Managed Care Organization (MCO)**, or a **Health Maintenance Organization (HMO)** where services have lower copays if the member sees an in-network provider. Most plans also require prior authorization for services.

Prior authorization is the process of obtaining approval of coverage for a treatment service or medication. It’s sometimes called pre-authorization, precertification, or prior approval. Each third-party payer may use a different term and has a different process. No matter what term is used, you will need to obtain this approval before treating a patient in order to receive payment for the service.

Have your pilot tester explain to the third-party payer that your agency would like to be able to bill for the client’s services as an **out-of-network provider**. The third-party payer will ask some standard questions.

3. Document authorization limits

If the service is authorized over the phone, your pilot tester must be sure to record the date and the name of the person who authorized the service. Record the authorization number, the number of units authorized, the next review date, and areas of interest for the next review. Give information to the treatment program providing the services that will allow them to collect the needed data and clinical information for the continued stay or discharge review.

That’s it for the first part of your pilot test. Did services get authorized? Why or why not? If not, what do you need to do differently next time? Run the pilot again, making changes based on the first pilot test.

4. Provide services

The next step in the pilot test is to provide the services that were authorized.

Reauthorizations or “concurrent or continued stay” reviews will continue for Steps 3 and 4 until the client is ready for discharge.

5. Record service provided and bill for appropriate amount

Now that you have authorization and have provided the authorized service, you can bill for services rendered. When you bill third-party payers, you need to use a standard form: the CMS 1500, sometimes also referred to as the HCFA 1500 form (for outpatient services) and the UB-04 (for residential treatment). Commercial payers and Medicaid use these standard forms.

Reminder: you will need to submit bills in a timely manner. Most payers require submission of a “clean” bill (a bill with no errors or missing information) within 30 to 60 days of discharge. Check the payer’s website for details.

Results of your Pilot Test

Did you get paid? Did you get a denial? What was the reason for the denial? Is it something that you can correct and resubmit?

6. Collections: Bill paid or denied

If you received payment—congratulations!

If the claim was denied, don’t despair. Third-party payers often deny claims because of problems with the bill rather than problems with the service. You can correct these errors and then resubmit the bill. Problems with the service are harder to correct since it has already been provided. But since this is a pilot test, you can learn from the experience. Make note of the corrections needed so you avoid the same problem next time.

7. Monitor receivables: Follow up with the third-party payer

If there were issues with the service—for example, the clinician did not have the appropriate credentials—your claim may be denied. Many third-party payers want people with higher levels of licensing than the state may require. For clinical and billing guidelines, visit the payer’s website and look for “Information for Providers.” You can make a change for the next billing opportunity that arises and run another pilot test.

8. Make corrections and resubmit bill

If you bill for just the first session, you can complete this pilot test within a three- or four-week time frame from beginning to end. This pilot test will give you valuable information about what you need to know in order to set up a billing system, even if you do several rounds of the test with slight modifications. Third-party payers typically have up to 90 days after the submission of a “clean” claim to pay the invoice.

The pilot test will teach you a lot about the information and processes required to work with third-party payers. You'll have to assign new tasks and develop new procedures and policies. We'll cover those in more detail in Part II: Creating a Billing System.

Part II: Creating a Billing System

Adding Medicaid or commercial insurance billing to your payer mix is sure to raise mission questions that you will need to address with your staff and board. You may experience “founder’s tension” between people who have worked for a long time in the organization, board members who may have helped create the organization, and executive management who are trying to lead the organization into a new payment environment.

- How will this shift in reimbursement affect the people you serve? If needed, will you change your service mix to adapt to what third-party payers are willing to purchase? Some of the people you serve will have insurance for the first time. How can you help them understand their coverage?
- How does this shift in reimbursement affect who you are as an organization, what you say about who you serve, and your role in the community?
- Does your fee policy need to change in light of **copays** and Medicaid and third-party payer requirements?

Consider all these questions and the clients you serve as you create your billing system.

But first you’ll want to think about your services. Do you know which of your services are actually billable?

Which of Your Services are Billable?

One of the first tasks faced by treatment providers that have never billed a third-party payer is determining which of the services they offer are, in fact, billable. Third-party payers restrict reimbursement based on client diagnosis, medical necessity, and clinician credentials.

When determining which of your services are billable, think of how what you are offering meets the client's unique needs.

Start with your program descriptions. How does this program description or clinician align to the third-party payers' patient placement criteria: outpatient, intensive outpatient, partial hospitalization, residential or acute care (detox)? Some third-party payers provide this information on their websites.

For more information on placement criteria, visit the American Society of Addiction Medicine webpage:

<http://www.asam.org/PatientPlacementCriteria.html>

What level of care are you providing? Does the way you describe your program meet medical necessity for that level of care? Some third-party payers provide medical necessity guidelines on their websites.

Look at the schedule of services and determine which parts are billable.

For group sessions in particular, examine what actually happens in the group. If the group includes an evidence-based practice like CBT, it includes a billable service—even if you call the group "Psycho-education." Hint: when you're looking at your schedule of services, ask yourself "Is this really what I do?"

"Many of our providers have a weekly 90-minute group they call "Psycho-education." This is not billable, but when we looked at what really happens in the group, we found that it included a 30-minute education style group, followed by a 50-minute process group. We determined that we could bill that portion as a therapeutic process group."

Clara Boyden, Manager, AOD, County of San Mateo, BHRS, Belmont, California

Once you've determined that the service is billable, follow the third-party payer's guidelines for coding and documentation. Make sure your client record includes the appropriate documentation for the service. Remember that you can provide a service that is billable, but if you don't document it in the client record in a way that meets the payers' requirements, it didn't happen.

Who does What?

As in any NIATx change project, you want to engage and involve your staff in making the transition to third-party billing. You also want to let your staff know that the executive management team is committed to making the change and supports all efforts to work effectively with third-party payers.

Creating a billing system or improving an existing one will change people's jobs. New positions, new work flows, and changes in communication patterns will affect your staff at all levels—even those who you would not think would be affected. Allow time for training staff on new processes. You'll also need to adjust and adapt those processes until you have a smooth system.

Engaging staff in the process helps ensure a successful transition. People need information about why the change is necessary, the proposed process of the change, and how it will affect their daily work. Ask for staff input on how to assess the new processes and procedures as they are implemented.

Changing the way you charge for services will change the intake/assessment, clinical service delivery, and discharge processes. You will add or change administrative processes such as obtaining prior authorization for services, **utilization review**, and billing for services. In addition to providing information and engaging staff in the change process, rewarding people for achieving system aims creates a strong motivator for embracing change. For example, some agencies pay bonuses based on collections. Helping employees enjoy the benefits of a new system will encourage them to support the change.

Who does what chart

Step in the Process	Who is assigned?	When is this task done?	Who is it handed off to?	Who else needs this information?
Verify coverage				
Request prior authorization				
Document authorization limits				
Provide services				
Document service provided				
Bill for appropriate amount				
Collections: bill paid or denied				
Monitor receivables				
Make corrections and resubmit				
Monitor cash flow				

Steps in the Billing Process

In the pilot test you learned what information third-party payers typically request. Now we'll go into more detail, guiding you through each step so you can create a process and develop forms and checklists that work for you.

Step 1: Verify Coverage

The first step of efficient billing is to learn everything you can about the coverage the third-party payer provides. Check the back of the patient's insurance card for contact information. You'll also need to know:

- Primary care physician information
- Total benefits covered
- Calendar year and lifetime maximum status
- **Deductible:** any met, and if yes, how much?
- **Copay** for all levels of care
- Claims address
- Certification (pre-authorization) phone number
- Lifetime maximum: amount met
- Policy termination date
- Effective date
- Authorizations required
- Name of person you spoke with

Some organizations have administrative staff make the verification calls and complete the insurance verification form. In other organizations, the staff member obtaining authorization for services also verifies insurance coverage.

Different insurance companies will have different procedures, but using a worksheet like the one that follows to gather standard information will help you as you start to work with these new payers. You can adjust the worksheet as you learn each third-party payer's requirements.

Checklist to Verify Coverage

Client Information

- Patient Name: _____ M F
- Address: _____
- Home Phone: _____ Other phone: _____
- Social Security Number: _____ Date of Birth: _____
- Primary Care Physician: _____
- Primary Care Physician's Phone: _____

Insurance Information

- Insurance Co: _____
- Policy No: _____ Group No: _____
- Insurance Co. Phone: _____ Fax: _____
- Policy Holder' Name: _____ Date of Birth: _____
- Policy Holder's relationship to client: _____

Client Eligibility and Benefits Information

- Date Coverage Effective: _____ Date Coverage Ends: _____
- Benefits for SA/MH treatment: _____
- Co-Pay Amount: _____ Deductible Amount: _____
- Prior Authorization Required for SA/MH? Y N

Step 2: Request prior authorization

Most plans also require prior authorization for services. Prior authorization is the process of obtaining approval of coverage for a service or medication with a specific clinician and network. It's sometimes called pre-authorization, pre-certification, or prior approval. No matter what term is used, you will need to obtain this approval before treating a patient in order to get payment for the service.

You will base your client's bill on the treatment and services you have provided that the payer allows. Most third-party payers now require you to get authorization before you deliver services.

What information do you need to obtain authorization? Check the third-party payer's website for guidelines and expectations for the services provided. Using their terminology will assist in getting services authorized.

Frequently, a clinician must actually see the patient to obtain authorization for an inpatient stay. For outpatient treatment, prior authorization may be completed prior to the first session.

Information requirements vary for each payer. Some companies will authorize an initial course of four to six outpatient sessions with minimal information. Others may want a full bio-psycho-social evaluation and diagnosis before authorization. Find out by talking to the provider relations service representative for the third-party payer, and then create a checklist so that your clinical or intake staff are guaranteed to collect the information needed for authorization.

See the example checklist on the following page.

Checklist for Prior Authorization

Date of call: _____ Time of call: _____

Third-party payer: _____

Prior Authorization Contact Name: _____

Prior authorization contact phone: _____

Fax: _____

Prior Authorization Approval No.: _____

Reauthorization required? Y N

Services authorized: _____

Authorization Limits: _____

Notes: _____

Call completed by (name) _____

Step 3: Document authorization limits

Determine who will be responsible for obtaining the authorization. Some agencies prefer to make this the responsibility of the clinician seeing the client. The clinician knows the most about the client and is committed to making sure that the client obtains appropriate services. On the other hand, this takes up time that the clinician could be using for billable services.

- Many small agencies make this an additional requirement for the clinical supervisor or program manager and reallocate some other administrative duties to administrative staff or the executive director.
- Other agencies centralize this process, designating a single person or a small team to obtain authorization. This allows the individual or team to develop better skills and closer relationships with the claims representative they contact regularly.
- Having a full-time staff member responsible for obtaining authorizations may be more realistic for a large agency rather than a small one. However, some organizations find that having staff devoted to the authorization process increases revenue collection to justify the cost of added staff.

Operation PAR in Florida hired a single staff person to obtain authorizations. This increased their third-party collections from \$129,000 to \$436,000 within one year, more than justifying the investment of \$30,000 for the staff salary.

Step 4: Provide services

Whenever your organization provides a billable service, you need to record the service in a way that will generate a charge. Clinical staff will need to keep progress notes current so services can be billed appropriately. Services must match authorizations in type, quantity, and be delivered by a clinician with the required certification. Appropriately credentialed personnel must provide the services authorized.

Part of developing a billing process is designating a person to collect information on services rendered and then generating an invoice or bill. Electronic health records (EHRs) were initially created for this purpose. Many organizations have adopted an electronic system for efficient billing.

But you don't need to purchase an expensive electronic system to start billing. Start by appointing a staff member to collect the information on services rendered and turn that into an invoice. That person will need to have a list of billing codes that match the **CPT codes** for the services you provide and instructions on how frequently to gather the information.

Ensuring that the clinical encounter matches the services authorized is a critical part of a third-party billing system. Agencies that have been billing for many years have established procedures to make sure the service matches the authorization. They have also established entire quality assurance processes for reviewing the success of their system.

Reauthorization (Concurrent Review or Continued Stay Reviews):

Payers initially authorize services for a short period of time. Designate a member of your team to obtain and document reauthorization for clients who need continued treatment. Payers companies vary in establishing authorization limits. With experience, you will learn the language necessary to obtain re-authorization for additional services. Typically, you will need to be able to describe:

- Course of treatment so far
- Treatment plan
- Why more service is necessary
- What you expect to do in the additional time you are requesting
- Need for level of care based on the client's severity
- Anticipated end date

The more specific you can be, the more likely you are to get additional services authorized. All appropriate staff need to be informed of the reauthorization. In many agencies, the same person who obtained the initial authorization also obtains the reauthorization.

Step 5: Record service provided and bill for appropriate amount

You have obtained authorization, you've provided a service, and now you can finally send a bill. It's time to set up your billing system.

First, you need to decide if you want to contract with an outside vendor or create your own billing system.

Contract with billing vendor

Using a billing service may be preferable (and economical) for a small agency.

Associations that certify medical billing vendors in some states include:

<http://www.ambanet.net/AMBA.htm> and <http://www.e-medbill.com/>

The Healthcare Billing and Management Association (<http://www.hbma.org/>) is an association of medical billers that lists members by the type of billing they do.

Vendors may charge a flat fee per bill, a percentage of fees collected, or a graduated rate based on volume. Vendors have experience with billing systems, will deal with all of the follow up necessary to get a bill paid, and sometimes guarantee collection rates. The downside may be that for providers with large volume, an in-house system may cost less.

When you contract for billing services, you'll need to add the vendor to the list of people that receive information about authorization and services delivered. Since a billing vendor will not be able to review a client record like someone in house, you'll need to set up a communication system so they get the information necessary to generate bills on a frequent and regular basis. Some vendors have web-based systems that allow you to enter data electronically. Others will help you design the communication system that works for your organization.

How do you handle your accounting? If an external organization is keeping your books, it probably makes sense for you to contract for the billing work as well. Your accounting firm/bookkeeper may also do medical billing, or may be able to recommend a reliable service. If you are doing your own accounting/bookkeeping, you may have the internal capacity to develop your own billing system.

When considering an outside vendor:

- Determine your billing needs
- Talk with potential vendors
- Speak with other agencies that outsource
- Request and contact references
- Select a vendor

Creating Your Own Billing System

If you choose to do your own billing, you will have to create a billing system. As we mentioned above, electronic medical records or practice management software offer an efficient but expensive option for billing third-party payers. We'll discuss the benefits of an electronic system later.

Forms

When you bill third-party payers, you need to use a standard form: the CMS 1500, sometimes referred to as the HCFA 1500 form, and the UB-04. Commercial payers and Medicaid use these standard forms.

Completing these forms properly will help ensure that you receive payment. A third-party payer may deny a claim if the form has missing or incorrect information. A missing birth date or social security number could result in an immediate denial. You'll need to know the various codes associated with the services and procedures you offer.

Coding

When you bill for a service, you assume responsibility for the accuracy of the required coding and documentation. Assigning the correct codes to diagnoses, procedures or services, and will ensure proper reimbursement from third-party payers. Accurate coding also captures the severity of the patient's illness.

We cover coding in greater detail on the following pages.

“Staff felt less overwhelmed by coding when they realized that they did not have to learn all the codes immediately, and that the addiction treatment services their agencies provide correspond to a limited number of codes.

Clara Boyden, Manager, AOD, County of San Mateo, BHRS, Belmont, California

Coding Overview

Know the services your agency provides, what billing codes to use to code those services, and the documentation requirements for those codes. This means that you must review the coding manuals and related documentation instructions. Coding and documentation requirements may vary by payer.

Many third-party payers' websites include guidelines for providers. Look for coding and documentation requirements for the clinical chart as well for the billing form. Visit the websites of various third-party payers to review the instructions that they offer. United Behavioral Health (Ubhonline.com) and Magellan (magellanprovider.com) offer entire sections on coding.

Remember that the client (clinical) chart has to back up the billing form. If the clinical chart does not correspond to the claim form, the payer might deny payment. A payer may even review claims submitted previously, and any inaccuracies uncovered could result in your having to return payment to the payer.

Consider creating an audit system to sample the documentation against claims to verify accuracy. Checking previously billed claims that have been paid also allows you to verify that you submitted the claim correctly, with the correct codes and modifiers.

In addition to knowing and understanding the codes, you need to have a system in place to ensure that your clinicians (or designated coding staff) know how to code services provided.

Some agencies hire a certified coder to review the clinical record and billing forms. Others engage an outside consultant to review documentation against the codes they expect to bill for, to verify accuracy independently. Using an outside consultant in this way will help you meet compliance requirements. If an accounting firm in your area already does a lot of work with medical providers, it may have knowledgeable staff available to help you with this kind of review.

The coding glossary and tips that follow will help you get started with coding.

Coding Glossary

Billing third-party payers will require that you and members of your staff learn the procedure, diagnosis, and revenue codes used for completing claim forms. Complete and accurate coding will reduce your denial rate and increase revenue.

Current Procedural Terminology (CPT) Codes

The American Medical Association developed and maintains Current Procedural Terminology Codes. These codes provide insurance companies and other payers with standardized information about healthcare services and procedures that a patient has received. CPT codes consist of five-character numbers.

The AMA publishes the CPT® Handbook for Office-based Coding, which is updated annually. It also publishes Stedman's CPT® Dictionary, which includes definitions of medical terms used in CPT code descriptors. Visit: <http://www.ama-assn.org/> for more information on these books and other training materials on CPT codes.

DSM Codes

"DSM Codes" refers to the *Diagnostic and Statistical Manual of Mental Disorders*. The American Psychiatric Association publishes this encyclopedia of codes. It contains lists of codes for every currently known mental health condition. For more information, visit: <http://www.dsmiv.net/dsm-iv-codes.html>

Healthcare Common Procedure Coding System (HCPCS)

The Centers for Medicare and Medicaid Services (CMS) develops and maintains HCPCS codes. These numbers are the codes required for billing Medicare and Medicaid. Like the CPT Codes, they provide standardized information about medical, surgical, and diagnostic services. For a list of all the current HCPCS codes, visit the CMS website:

http://www.cms.gov/HCPCSReleaseCodeSets/01_Overview.asp#TopOfPage

International Statistical Classifications of Diseases (ICD-9) Codes

The World Health Organization develops, monitors, and copyrights ICD-9 codes. These codes are sets of alphanumeric characters. They are used to group and identify diseases, disorders, and symptoms. These codes also create international standards for collecting, processing, and presenting mortality statistics.

ICD-10 Transition on October 1, 2013

ICD-10 codes must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2013. Otherwise, your claims and other transactions may be rejected, and you will need to resubmit them with the ICD-10 codes. This could result in delays and may affect your reimbursements.

Modifiers

Modifiers are two-digit codes appended to CPT and/or HCPCS codes. They provide additional information about *who* provided the billed procedure. You can find these modifiers in the CPT and HCPCS coding manuals. Third-party payers will also specify which modifiers you can use. In some cases, adding a modifier may directly affect payment.

Revenue Codes

Revenue codes are three-digit numbers that are used on hospital bills. Agencies that offer hospital- or facility-based treatment need to use revenue codes. These codes indicate what kind of hospital treatment a patient received, and they must match the correct CPT code. This may vary by third-party payer, so be sure to review each payer's coding guidelines. If you do a single-case agreement to cover hospital- or facility-based treatment, clarify the coding specifications at the time of the agreement. Ask the third-party payer to send you an example of a properly completed claim that shows the appropriate CPT and revenue codes.

Service Codes

Treatment organizations use service codes to track a specific treatment service. These codes, also referred to as activity codes or class codes, correspond to CPT, HCPCS, ICD-9, or other codes. Many electronic medical record and billing software packages include pre-defined service codes.

Coding Tips

Beware of same-day service restrictions. Many payers will not pay a claim if a physician sees a client on the same day that a therapist provides a service. If a patient sees a physician for medication for opioid dependence and a substance abuse treatment counselor for behavioral therapy on the same day, only one of those services will get paid. In most cases, the first service that hits the system will get paid, and the other will be declined as duplicate.

Beware of restrictions, but alert to opportunities. Some agencies do not bill for the last day of inpatient detox treatment. That means that they can bill for outpatient or intensive outpatient services on the same day a patient is discharged from inpatient detox without risk of denial due to same-day service restriction.

Read your contract and know the limitations. A contract may state that you can bill for individual and group therapy, using CPT code 90806 for individual therapy, or 90853 for group therapy. But if you bill for family therapy, using CPT code 90847, the claim will be denied because family therapy is not part of that contract.

Know the credentials and scope of practice for your clinicians. A third-party payer may pay a different rate for the same service, based on the clinician's credentials. In many states, a payer will reimburse a service provided by a licensed therapist at a higher rate than the same service provided by a staff member with a lesser credential.

Credentials and scope of practice may determine if you bill the service under the clinician who actually delivered the service, or under the physician supervising that clinician. To bill under the physician, you need to add one of the modifier codes. This tells the payer that the service was not actually performed by the physician but by someone with lesser credentials under their supervision, at a lower reimbursement rate. Attempting to collect at the higher reimbursement rate (i.e., a physician's rate for a master's level therapist) may be considered fraud.

Credential requirements for the same service may vary by payer. Know what credentials are needed for each service for each payer. Medicare and Medicaid often have different credential requirements for the same service.

Be on the alert for place of service restrictions on codes. If a service is office based, you can't provide it in a client's home. The CPT manual lists place of service codes.

"Incident to billing" indicates that the service is connected to care that a doctor is providing. Using this code in behavioral health will raise your reimbursement rate, but you must follow the guidelines meticulously. One key requirement is that the physician must literally be in the office where the service is being delivered. Medicare provides very good instructions to follow for using the incident to billing modifier.

Creating Your Own Billing System, Continued

Establish a Billing Cycle

Establish a regular billing schedule to keep consistent cash flow. Your billing success is tied to the accuracy of billing and invoice content, as well as to the steps in the process described in the previous pages:

- Verifying coverage
- Obtaining and documenting authorization
- Making sure that services are provided by appropriately credentialed personnel
- Communicating service delivery information in an accurate and timely manner to all people engaged in the billing process

Generally Accepted Accounting Principles (GAAP) is a collection of rules and procedures and conventions that define accepted accounting practices. Organizations typically use GAAP when setting up a billing system. However, many states have their own accounting rules that will affect you if you continue to accept grant funds. States also issue different reporting requirements. Each organization needs to establish internal procedures for detailing revenue recognition. Consult an accountant experienced with these issues as you adapt your accounting practices.

With a billing system, collection rates become important. If your accounting system is **accrual-based** (the most commonly used accounting method, which reports income when earned and expenses when incurred), you will record income when it is billed, not when it is received. Then you have to watch cash flow and keep an eye on receivables to make sure that you don't have too many accounts more than 60 days in arrears, or your income, which will seem to be growing with all of this new revenue, will be an illusion.

An agency must realistically assess its business office operation and capacity. In the past, you may have been able to keep overhead rates low by limiting business office operations because you didn't have to focus on revenue generation. In a new environment where billing third-party payers is key to survival, the business office must manage revenue sources, cash, and develop an understanding of the unit cost of services.

Generating Bills

Who will generate the bills/invoices and send them to the correct payer? Your accounting software probably already has the ability to generate charges with appropriate data entry. The person responsible for the bookkeeping function in your office can collect the information on which company to charge for which client. This staff person will also verify how many units of service were authorized and at what rate from the information gathered during intake. A smaller organization may have a weekly or monthly billing cycle. In a large organization, billing may be a daily task and the sole responsibility of an individual or a team of billing clerks.

If you contract for bookkeeping services, be prepared to renegotiate your contract for the additional bookkeeping work. You also need to add the contracted bookkeeper to your list of people who need to receive the information on services that have been billed.

Step 6: Collections: Bill paid, denied, or no record of response?

Staff responsible for collecting payments must become familiar with the third-party payers’ rules and payment behaviors. They must know the turn-around times and gain an understanding of how length of stay, level of care, patient volume, patient acuity, and billing volume affect collections. Each insurance company has its own set of rules, and departments within a company often operate as silos. The “eligibility” group operates independently from the “authorization” group and each operates separate from **accounts payable**. Negotiating the communication barriers can be challenging.

Step 7: Monitor receivables: Develop a follow-up process for bills not paid.

Accounting staff or a member of the management team will have a new task in monitoring receivables. To best monitor accounts receivable, generate aging reports from your accounting system. An aging report lists accounts receivable balances by customer, detailing the current status or delinquency of the balances owed or owing. Initially, you will want to pay attention to claims that are more than 60 or 90 days overdue. **Note that you’ll have to keep an eye on your cash flow. Make sure you don’t have too many accounts more than 60 days in arrears or you won’t be able to cover all your expenses.**

Sample Aging Report:

Agency ABC A/R Aging Summary						
As of June 29, 2011						
	Current	1 - 30	31 - 60	61 - 90	91 and over	Total
Company I					9,000.00	9,000.00
Company II			9,400.00			9,400.00
Company III					7,125.00	7,125.00
Company IV		1,340.89				1,340.89
Company V		1,411.00	1,911.00		16,510.48	19,832.48
Company VI					2,641.00	2,641.00
Company VII	2,895.00	3,151.50	1,964.00		5,892.00	13,902.50
TOTAL	\$2,895.00	\$5,903.39	\$13,275.00	\$0.00	\$41,168.48	\$63,241.87

Step 8: Make corrections and resubmit the bill

You'll want to understand why a claim has not been paid. Is it due to billing errors or rejected claims? Define the rejected claims specifically. Does a particular third-party payer routinely reject a certain service? In identifying the reason that claims are rejected, you will be able to identify processes you need to adjust and systems that you need to improve. You will also begin to identify which companies you want to continue to work with, based on payment performance.

In Part III: Improving your Billing System, we'll briefly cover some of the business practices that can help increase your collections from third-party payers.

Part III: Improving Your Billing System

Business practices that influence collections

Once you have set up a billing system, the next step is to look at how to increase collections in your system. The billing operation itself does not stand alone as the source of successful payment. The qualities required for successful collection exist in the agency's business and clinical processes and practices. Some of the non-billing influences that directly affect collections include:

- Utilization management
- Compliance
- Metrics
- Seeking contracts for your services

Utilization Management

With prior authorization, you and your team have an initial impression of the client's immediate services needs, the estimated length of stay or treatment, and what the client will need upon discharge. You actually start your discharge planning at admission. Each third-party payer will provide you with its clinical guidelines. These will allow you to prepare for the standard reviews of your services. The guidelines also describe the payer's requirements for continuing care. In many cases, third-party payers require that your organization schedule the continuing care appointments before the client's discharge.

Knowing the third-party payer's continuing care and discharge criteria is just as important as knowing the payer's clinical criteria for admission to a level of care. This allows your agency to ensure that client is getting the level of care most appropriate for the symptoms demonstrated. This also gives your utilization management staff the correct clinical information. Again, requirements for clinical care authorization as well as continuing care will vary by third-party payer.

Medical Necessity or Level of Care Guidelines

Many third-party payers post their level of care guidelines online. United Behavioral Health Plan, California is just one of many third-party payers that offer online access to its guidelines, detailing what a program needs to provide for a specific level of care, along with the clinical information to justify that level of care:

<https://www.ubhonline.com/html/guidelines/levelOfCareGuidelines/index.html>

This online information helps you prepare for treating clients covered by a particular payer. It will often list the providers that are part of the payers network. By examining this list, you can find out what services other providers offer. If they offer a service you don't offer, you can begin to build a relationship by making referrals (which in turn can lead to receiving referrals from them.)

Medical necessity or level of care guidelines ensure that the client receives the most appropriate and least-restrictive level of care necessary. The continuum of care for substance abuse treatment is fluid; clients may enter treatment at any level and move to less or more restrictive treatment based on their clinical need.

Magellan Behavioral Health defines medical necessity as “Services by a provider to identify or treat an illness that has been diagnosed or suspected.” The services are:

- Consistent with the diagnosis and treatment of a condition and the standards of good medical practice
- Required for other than convenience
- The most appropriate level of service

When applied to inpatient care, medical necessity means the needed care can only be given safely on an inpatient basis. Medical necessity guides both the clinician and the third-party payer reviewer to the most appropriate level of care for the client. All medical necessity decisions are made after reviewing the description of the client’s current clinical condition gathered from a face-to-face evaluation. Since not all levels of care are available in all areas, many third-party payers will support the client’s treatment through extra-contractual benefits. Or, the payer may authorize a higher level of care to ensure that the client receives all necessary services for safe and effective treatment.

Codes to match services

A system for identifying your services is key. The billing codes that you use need to match the codes for the service that has been authorized.

Know the expectations for discharge and continued care

A client has been authorized for services. You’ve provided some services, and the client demonstrates a need for additional treatment. What now? Your team already has the answer to that question, since during the initial authorization (pre-certification) your staff asked the third-party payer what clinical information was expected for further review, and who to call. Plus, you have the guidelines for medical necessity and level of care available for review.

The third-party payer will expect that only medically necessary services are delivered. The reviewer will have guidelines for the symptoms and situations that demonstrate medical necessity. Learn and adopt their language to assure continued appropriate care for your client. You will also need to ask:

- What clinical information will you be looking for the next time we speak?
- When do we need to review again?
- What additional information about the client do you need for the next review?

Know the requirements if services are denied

You attempted to authorize a session and the third-party payer denied the case. What do you do? Find out why they denied the authorization. Here are a few steps to help. Understanding these steps and learning what was missing can help prepare for the next case, so you won't be denied. Remember, you can appeal a denial. If there is a strong clinical case, there is a good chance that your agency will be able to overturn the decision on appeal and get paid. Questions to ask the third-party payer:

- What exactly was missing that the case was denied?
- Was the reviewer looking for clinical information?
- Was this information requested at the last review?
- Does the reviewer require an update on the previous authorization?

Documentation: Document every step you take. Remember, if it's not documented in the record, it did not happen.

Ask for an expedited peer-to-peer or doctor-to-doctor appeal. Appeals should be available within 48 hours of the denial. This level of appeal is often called a "Doctor-to-Doctor," which may in fact involve the third-party payer's medical doctor speaking with a staff member at your agency.

Continued denial

A payer that continues to deny the certification is required to provide alternative recommendations. At this point, the client or the client's family can decide whether to continue services or to accept the third-party payer's recommendation.

The client may want or need to continue treatment at your agency. Many third-party payer contracts indicate that clients cannot be billed for services that have not been authorized. The provider agency is required to notify the client of the denial and the reason for the denial. The client then can sign a form indicating they desire to continue the treatment and will be responsible for the fees.

Ask for the steps for a written appeal

Upon discharge, review the clinical chart. Is there clear documentation that the client needed this level of care? If no, don't appeal. If yes, take the next step. Does your clinical documentation clearly describe the care the client received in your program? Be sure to include outreach to the client for no-show appointments, coordination of services, etc.

- Copy the clinical chart and send it with an appeal letter.
- Clearly outline in your letter (using the payer's guidelines and terminology) why the client met the criteria for the services you are appealing. Refer to specific areas in the clinical chart to justify the level of care.
- Consider using FedEx or US Postal Service with return receipt to mail the letter, so you know it was delivered.

- Follow up: two weeks after sending the letter, call to follow up on the status of the appeal. Continue to call until you receive a determination.

Claim paid or denial upheld

What did you learn? What do you need to change to avoid denials in the future?

All agencies get denials, so don't feel bad. The key is to view this as a learning experience. Was the case upheld, because the information provided in writing did not match the information provided over the phone? Does documentation for detox indicate a client with normal vital signs and resting comfortably, thus not demonstrating in the clinical chart a need for that level of care?

Compliance

Contracts with third-party payers create a heightened attention to compliance with their requirements. If your state licenses or certifies treatment providers, you already know the mandated rules and regulations. Third-party payers have their own rules and regulations as well; ideally, they do not contradict state regulations. Review the requirements before you sign a contract. The American Medical Association offers a guide on contracting with insurance companies:

<http://www.ama-assn.org/ama1/pub/upload/mm/368/15questions.pdf>

After you have a contract, set up a system to monitor compliance. You'll need to ensure that you are in continued compliance as an organization, as well as for each service you provide to an individual covered under that contract. Since you probably already have a process to monitor compliance for state licensing/certification/contracting, you will need to add the items mandated by your new contract(s) to the list of activities you monitor.

This is where quality assurance and utilization review become a stronger part of your standard operating procedure. Not only are you monitoring to ensure that records are kept according to regulation and that facilities meet standards. Now you need to add adherence to the payer's reimbursement rules.

- Are client services pre-authorized when necessary?
- Do services get reauthorized in a timely fashion?
- What is the rate of denial for reauthorization?
- What is the reason for denial?
- Are clinicians assigned to a particular client approved by that client's payer?
- Are clinical notes kept up-to-date so that billing is done in a timely fashion?
- Are bills completed and submitted properly?
- What is the collection rate?
- What is the reason for non-payment?

New Tasks to Assign for Compliance

Claims review

Assign a person or a group to stay on top of payment denials and the reasons for them. The information this person or team gathers will help you identify and address the most common reasons for denials. Payers often deny claims because treatment services were not authorized properly or were performed by a clinician without the required credentials. Other reasons include incorrect service codes or patient information.

Revenue Management

A person or group needs to monitor cash flow and collections. Accounting staff needs to meet with the team regularly to examine and improve the processes related to revenue management.

Utilization review

A person or group of people will need to be responsible for reviewing client records and ensuring that your agency is meeting standards. Establish a schedule for reviews and a process for addressing issues that result from the reviews. Develop a utilization review checklist.

Utilization Review: Tips from WPS Health Insurance

WPS Health Insurance is a large benefits provider based in Wisconsin. Founded in 1946, this not-for-profit insurer offers health plans statewide to the public and private sectors.

Jim Sarnosky supervised the behavioral health managed care team at WPS for 14 years. One of his tasks as a senior managed care coordinator was doing an annual assessment of the utilization review (UR) criteria for outpatient and inpatient substance abuse treatment. WPS works with almost 150 treatment providers across the state.

“The purpose of a UR interview is to establish the medical necessity for treatment so we as the payer can make a judgment about whether to pay for it,” says Sarnosky. “It allows for discussion of the most appropriate course of treatment for a patient.”

Before joining WPS, Sarnosky worked as clinical coordinator for inpatient adolescent programs at Tellurian, a treatment organization in Madison, Wisconsin. He offers the following tips for providers participating in a UR interview for inpatient substance abuse treatment.

“At WPS, this interview is usually a phone conversation between a WPS managed care coordinator and the provider’s UR coordinator or patient care specialist,” explains Sarnosky.

Be prepared to list all of the patient’s diagnoses. “Have all the information about the patient in front of you,” says Sarnosky. “Responding with incomplete information or saying ‘I don’t know’ will suggest that you aren’t fully prepared.”

Explain the reason for admission to treatment. Did the patient show up voluntarily, or because a spouse is threatening divorce? Were the police involved? You may also be asked to assess the patient's level of motivation. Is the patient self-motivated—sick of being sick? Patients who are at risk of harming themselves or others or those in an acute phase of withdrawal are more likely to be admitted for inpatient treatment.

Provide information on previous attempts at treatment. “Surprisingly, providers often miss this,” says Sarnosky. “This indicates that the clinician did not conduct a thorough assessment.” Previous attempts at treatment are not unusual in substance abuse treatment and can point to the severity of the disorder. Utilization review is an opportunity to examine those previous attempts and avoid repeating treatment that has not worked in the past.

Describe symptoms of substance abuse withdrawal: tremors, sweating, and visual or auditory hallucinations. This is a place to use the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA) or the Clinical Opiate Withdrawal Scale (COWS). Most managed care organizations use these scales

What is the patient's level of support. Is a family member willing to take the patient to 12-step meetings? Does the patient have a recovery network at home or in the community? An intensive level of care might be more appropriate for someone returning to a home where a family member is still using alcohol or drugs.

You may be requesting a service for a severely intoxicated client who may be unable to provide information about his or her level of support. Think about how you can convey missing information in a positive way. “That's something we will explore once we have developed a rapport with the client ” is a stronger response than “I don't know.”

What medications have been prescribed for the patient? Is the patient taking them as prescribed? If not, can you explain why?

Describe the plan for aftercare. How will the patient maintain recovery after completing inpatient treatment? “Aftercare tends to be more successful when the treatment provider makes the arrangements, rather than leaving it to the patient. The more specific you can be in describing aftercare arrangements, the better.” Be prepared to share information on the recovery group and/or outpatient program that the patient will be linked to.

Indicate recommended length of stay. Clinicians need to consider many factors in making the best clinical decision about length of stay. “A fixed length of stay—say a standard 28-day program—may be questionable because it doesn't take into account individual levels of progress and motivation on the part of the patient,” says Sarnosky. “Some clinicians prefer to assign an appropriate level of care and length of stay after observing a patient for three days.” If that's the case, be prepared to describe what will

happen on each of the three days, and how this will help you develop a comprehensive treatment plan.

What is the discharge plan? A third-party payer will look favorably upon a treatment plan that includes continuation of treatment. Describe how you'll make seamless the patient's transfer to the next level of care.

Managed care plans have guidelines specific to step-down care and/or follow-up appointments with mental health and substance abuse clinicians and primary care physicians. Healthcare reform mandates that every client in a detox or residential program must have a follow-up appointment with a primary care physician. For patients completing outpatient care, the clinician must correspond with the primary care physician.

Describe the plan for family therapy. Many programs have a "family weekend" or "family night," which is part of an established schedule. For some patients a better option might be to schedule one or two family sessions upon admission. The main thing the third-party payer wants to know is that there's been an attempt to involve the patient's support network outside the treatment center.

Other advice? Sarnosky encourages providers to find opportunities to get educated about utilization review criteria. "Treatment providers are often not prepared for the kinds of questions the third-party payer asks during a UR interview." Some professional conferences offer workshops on UR. "You can also contact another provider to see if they offer consultation services and training on UR."

Sarnosky says one of the biggest challenges behavioral health providers face is finding the resources to dedicate to a UR position. Someone in this position should have a strong clinical background and be able to communicate effectively. "A person who does UR full-time knows how to provide the information that the third-party payer is looking for," adds Sarnosky. "Regardless of the size of the organization, this can be a full-time activity and will bring in more treatment approvals. With the extra revenue that generates, this position quickly pays for itself."

Metrics

The metrics you monitor should cover financial, quality, customer outcomes and satisfaction, and employee performance measures. By measuring key areas and communicating the information with program staff, every program is able to develop quality improvement projects.

Contracting with a third-party payer will provide a powerful incentive to monitor customer satisfaction, access, retention, and outcomes. Third-party payers use these criteria to determine who are the best providers available for their members.

Performance criteria must be kept simple and clear. An individual or a committee should monitor the compliance indicators and generate benchmarks for performance improvement. The essential benchmarks focus on mistakes that cost money and mistakes that cost time.

For ideas on how to measure and improve quality, visit the NIATx Provider Tool Kit:
<http://www.niatx.net/Content/ContentPage.aspx?PNID=2&NID=16>

Seeking Contracts for Your Services

Once you have the capacity to bill, contracts become the next big driver for growth in collections. Many managed care companies discourage their members from seeking services outside of the network. They may pay a lower rate to out-of-network providers, if they pay at all. Having contracts with selected payers will generate referrals and improve collections for your agency.

Steps in the process:

Step 1: Know the state requirements for operating your business and providing treatment services.

Step 2: Conduct a service coverage analysis. Who are the largest insurance organizations in your area? In some parts of the country, one insurance agency provides the bulk of coverage; in others there is more choice. Are they accepting new providers? Is there a service that they are low on that you could offer?

Step 3: What are the workforce requirements? Depending on the level of contracting, the third-party payer may look at individual clinicians or at the facility as a whole. The third-party payer may require that individual therapists be licensed for the state in which the client resides. Many agencies opt to contract as a facility, so their internal requirements and credentialing are the standards. Facility contracting is not limited to inpatient programs, but can also be used for day treatment, intensive outpatient and outpatient services (including e-services).

Third-party payers may have stricter education or experience requirements than those the state mandates. Do you have the workforce with the certifications required to deliver the services for which you want to contract? What changes can you make, either through getting credentials for existing staff or through changing hiring practices?

Another example is contracting services at a case rate. In this scenario, the client receives services for a set amount of money while they are in need of services. This means that the third-party payer would pay the same amount regardless of the number of treatment sessions the client attends.

Think big when contracting with the third-party payer. If you provide ambulatory detox at

a site, would these services also meet the criteria for day treatment? If a client did not meet the third-party payer's medical necessity criteria for ambulatory detox, could you get days authorized as day treatment while the client attended the services?

Step 4: Contact the third-party payers or managed care companies you have identified in this process. Ask for a benefits manager, provider relations representative, or a medical director. Ask about their philosophy, mission, and requirements for clinicians. Find out how you can get on their "panel."

Identify payers whose mission and reimbursement policies align with those of your organization. This will help you select the payers most likely to provide reimbursement with the least hassle. This exercise will also help you recognize where you must make internal changes to maximize reimbursement.

Step 5: Fill out the payer's application form. The payer may have specific requirements, but information requested may include:

- Description of your agency, its services, and treatment protocols
- Resumes for key staff highlighting their credentials
- Accreditation/licensing credentials (JCAHO and CARF often required)
- Insurance/malpractice information
- Admissions and discharge criteria
- Utilization review (UR) data
- Licensure
- Program description or calendar for daily events, evidence-based programs, variable lengths of stay

Providing 30-, 60-, and 90-day treatment outcomes and access and retention data may also be useful.

Step 6: Site visit: the third-party payer may schedule a time to visit your organization during the application process. Assign an individual or an internal committee to manage the site visit. Internal awareness will contribute to a successful site review. Many third-party payers may request a copy of a chart, your policies and procedures, and your licensure review. Some will also call former clients after their discharge. Some may ask your state for the last audit of your program and any outcome studies. This may not be required if you are JCAHO or CARF accredited.

Step 7: The contract process centers on negotiating rates of service. Unfortunately, rate variations exist across and even within states. Your goal in negotiating rates is to have the insurance company or third-party payer buy all services at "normal rates." What does this mean? You want to have the rate cover the cost of providing the service plus a cushion or small profit. If you have never figured out the unit cost of service, you will have some calculating to do.

In some states Medicaid rates represent the base for reimbursement, while the higher rates set by certain large third-party payers become the ceiling. The person negotiating for your agency must be knowledgeable about services and rates and have the authority to agree or disagree with the third-party payer's rate range. It is easier to have agreement about common services than custom services.

Collection rates from third-party payers can vary significantly. A Massachusetts agency attributes its 98 percent collection rate to multi-year experience with third parties, strict processes in billing and collection procedures, and stringent internal rules on contracting with third parties. In contrast, the collection rate for an Illinois agency new to third-party billing was only 45 percent. For both agencies, negotiating the contract is just one aspect of the "contract impact."

Credentialing through a clearinghouse

Many third-party payers now require that agencies use an Internet-based clearinghouse to complete credentialing requirements. The Center for Affordable Quality Healthcare, Inc. (CAQH) is one of the most frequently-used Web services for credentialing.

CAQH offers an online database called the Universal Provider Datasource (UPD) that collects all of the information required for credentialing, then makes it available to third-party payers. Agencies that use the CAQH clearinghouse no longer have to complete lengthy paper applications for each third-party payer they want to contract with. CAQH does not require a fee to agencies that use their service for credentialing. The CAQH website provides instructions and an online tutorial.

For more information, visit:

http://www.caqh.org/ucd_physician_faq.php

Becoming a Preferred Provider: Tips from Fayette Companies

Fayette Companies in Peoria, Illinois, earns the majority of its revenue from state contracts, but has also been contracting with third-party payers for over 20 years. David Moore, vice president of quality improvement, offers the following tips for becoming a preferred provider or part of the “panel” with a third-party payer.

Read the contract thoroughly. In addition to the CFO, have people from different areas of your organization review the contract for elements that affect the work they do. A central access manager will have different concerns about the contract than a billing manager.

Read the provider handbook. Make sure that staff at all levels of your organization become familiar with the third-party payer’s requirements and processes.

Understand the process for appealing a denial. Adds Moore, “If you’re new to working with third-party payers, you may miss a lot when you’re reviewing the contract and the provider handbook. Call another provider already in the network and ask their advice for working with that payer.”

Keep staff informed. Develop a system for sharing and updating information on the contracts you’ve established. Consider creating a “cheat sheet” that lists the name of the payer, the name of your agency’s key contact person there, phone number, and reimbursement rates for the services covered in your contract.

Develop a relationship with the contact person at each third-party payer.

“At Fayette Companies, contracts often arise from doing single case agreements for a client who is covered by a particular third-party payer,” says Moore. “Your relationship begins the first time you work with that payer.”

Designate a member of your staff to monitor the status of your provider contracts.

This includes paying attention to “re-credentialing,” or renewing your contract according to the timeline set by the payer. “When you re-credential, this is also the time to renegotiate your rates,” says Moore.

Set goals. As you gain more experience with billing third-party payers, develop a strategy and set goals for adding more contracts. Find out which third-party payers cover the largest employers in your area, and pursue contracts with them.

Market your menu of services. What differentiates you from other treatment agencies in your area? Do you have bicultural/bilingual staff who can offer appropriate services to a culturally diverse clientele? “At Fayette Companies, offering medication-assisted treatment and ambulatory detox with buprenorphine was a market differentiator when we negotiated with managed care companies for contracts,” says Moore.

Developing Relationships

Most third-party payers, including Medicaid, have a provider relations department that you can contact with questions. Check the organization's website or the client's insurance card for contact information. In time, staff members who obtain verification and authorization will develop invaluable relationships with the payers' service representatives. A third-party payer may offer a member seeking treatment three referral options, you can increase the odds that your agency is one of them by building positive relationships. Payers will refer clients to your organization based not only on the quality of care you provide, but also on the quality of your working relationship. A mutually respectful relationship will benefit your organization and the clients that you both serve.

As your relationship grows, so will the third-party payer's confidence in your treatment integrity. Your staff will learn exactly what clinical information the payer requires, leading to an increase in treatment certifications and revenue. Over time, this positive relationship will increase staff efficiency, which also has a positive impact on revenue.

It's important for you to get to know the key contacts at the third-party payer. You'll get to know the person who you worked with to establish the contract. You also want to build a relationship with the staff members who refer clients to your organization, as well as those who provide authorizations.

Make a point to stay in contact with those individuals. Call to thank a payer for a referral. Check in on reviews of past referrals. Is the payer seeking a specific service that you can provide for its members? Tell the payer about any new services you're providing and keep them up-to-date on the evidence-based practices that you're implementing. This regular contact serves a dual purpose: it keeps your agency in the forefront and allows you to find out about opportunities for growth.

There may be times when you feel that the payer's requirements are demanding or counter-productive. But the key to building this relationship is to focus on the client. You and the third-party payer are both working for the client; you both want to make sure the client gets the best treatment possible. You're on the same team. With great teamwork and effective communication, you'll help the clients you serve reclaim their lives.

Through monthly check-in phone calls, Agency W learned that a third-party payer had ended its contract for partial hospitalization with another organization. This opened the door for Agency W to examine its programs. Agency W determined that it could add this service level, with a cost of \$30,000 annual salary for a group leader. It contracted for this service with the payer and over the next year brought in \$78,000 from the payer, not counting copays.

Information Sharing: Internal Communication

Effective internal communication at your organization is just as important as your communication with the third-party payer in obtaining authorization, and eventually, payment for services. You'll need to share required information for all relevant internal systems:

- Scheduling
- Registration
- Treatment/case manager
- Business office
- Utilization Review staff

Identify who will disseminate information to all the people that need it. The authorization information must get to everyone that has a hand in the billing process. The service delivered and the bills generated for this service must reflect all payers' conditions, such as level of care, units of service, and clinician's credentials.

Include the authorization information in the part of the patient file that all relevant staff have access to. Or, create an information sheet that gets copied to all staff. An electronic health record (EHR) offers an efficient way to disseminate the required information to the appropriate people, but other processes also work. Some organizations use a central database or a simple spreadsheet.

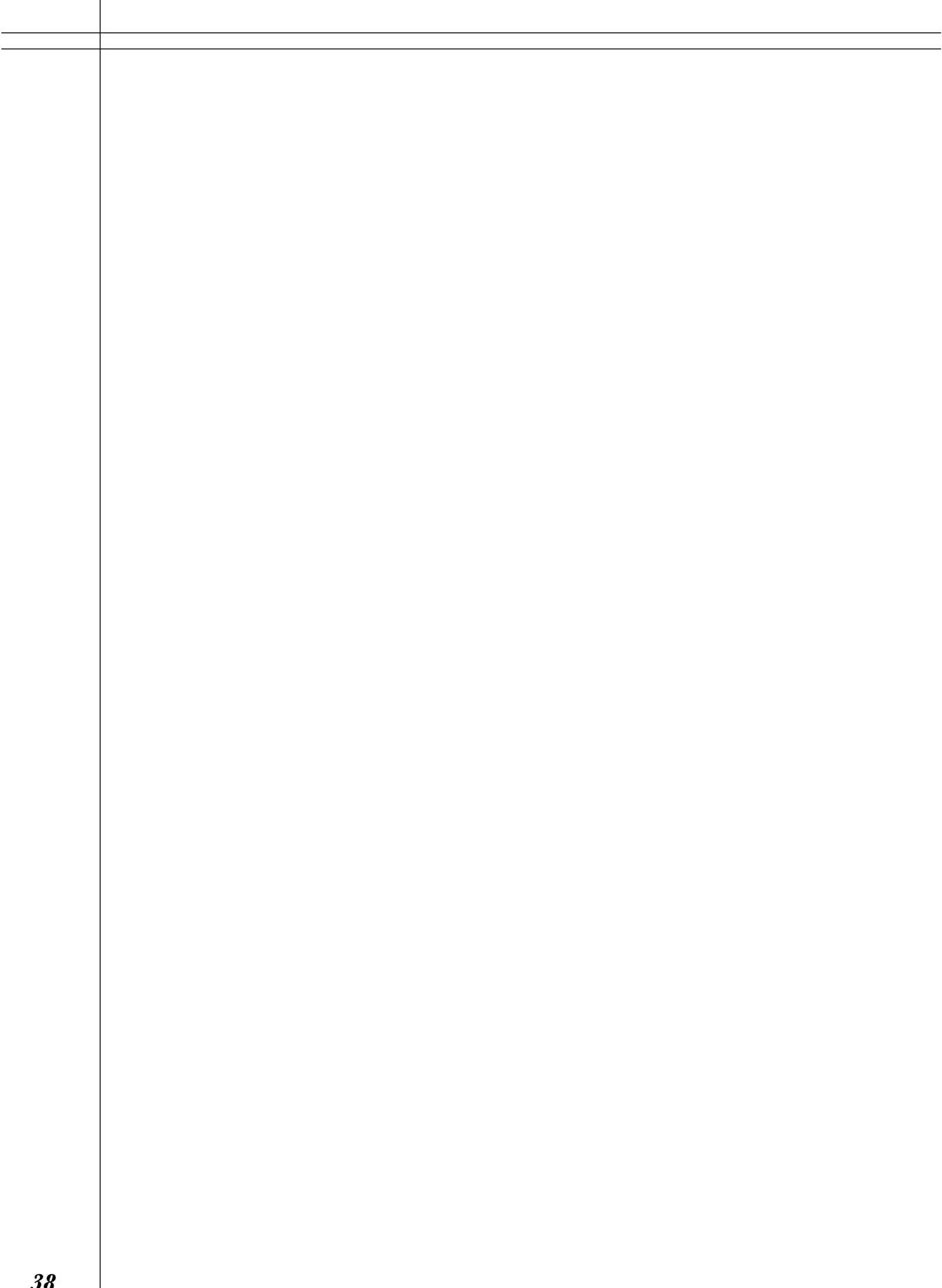
The clinical team needs to be informed of authorizations, as well as areas the third-party payer will be examining at the next review. Your business office or billing office needs to know what to bill, for how much, and how and where to send the bill. The client needs to know what the third-party payer is going to pay for. Staff who will be doing the next review or discharge planning need to be fully informed.

Getting the information to the right people can be a challenge in organizations where each team member may be doing more than one job. How can you make sure that the right people have access to the right information?

Take a look at how information flows in your agency.

- Does everyone use e-mail and have access to a shared calendar?
- Do you use Excel or other spreadsheet programs?
- Microsoft Access or other relational database programs?
- An electronic medical record program? A dry erase board? An Intranet site?

Consider setting up a shared calendar system (like Microsoft Outlook) that all staff can view. You can set up separate calendars for each program or clinician. This calendar should be the same one that clinicians or programs use for scheduling appointments.



Part IV: Taking It to the Next Level

Setting Goals





Set goals for the amount of revenue you want to generate through your contract with a third-party payer, and monitor your progress toward that goal each month. Let's say you set a goal for one of your programs to bring in \$60,000 per year from a third-party payer. Your monthly revenue goal is \$5,000. Within the first week of each month tabulate the expected revenue authorized from the previous month, the actual revenue received (you have check in hand), the variance for the month and for the year to date.

Utilization Management Report Apr-06

SAMPLE OPERATION PAR - 727.499.2337

Projected Insurance Revenue for 2005-2006 based on Budget meetings.
* based on report from 5/01/06

Program	Detox	IOP
Projected Revenue - Yearly	\$165,000.00	\$29,000.00
Projected Revenue - Monthly	\$13,750.00	\$3,222.22

Estimated \$ based on Precertification	\$18,630.00	\$120.00
\$ due from client for copay	\$3,540.00	\$60.00
Total	\$22,170.00	\$180.00
		
Expected Revenue - MONTHLY		
Variance Monthly	\$4,880.00	(\$3,102.22)
Expected Revenue - Yearly	\$151,250.00	\$35,444.42
Actual YTD revenue	\$155,087.00	\$8,729.00
		
Variance for Year to Date	\$3,837.00	(\$26,715.42)

Operation PAR's "Piggy Report" shows program managers what progress they're making toward their revenue goals. The report provides exact numbers so managers can make adjustments to meet the goal.

Copays

Every service provider will eventually need to develop a clear and comprehensive fee policy that is sensitive to community norms. Many agencies discover that patients expect and are willing to pay for services. Most people do pay for services. Other agencies have discovered that concerns about copays drive patients away and that the organization is better off financially by not focusing on payment issues.

Whatever the choice of your organization, be sure to convey a clear and consistent message.

If you are going to work on collecting patient payments, decide who will pursue those collections, and at what point. What happens when clients are not making payments during treatment? Who should initiate the discussion with the client? The clinician, the business office, or both?

Promising practices for collecting copays

CAB Health & Recovery Services in Peabody, Massachusetts increased collection of copay or self-pay fees from 40 percent to 90 percent by requiring clients to pick up a service sheet at the front desk, pay all co-fees, and update any insurance information when they entered the office. Then the client attended the scheduled service and provided the sheet to the clinician. The clinician verified that the client was in the right group, and verified attendance and service rendered by signing and returning the billing sheet to the billing supervisor. <http://www.niatx.net/toolkits/provider/cab-outpatient.pdf>

BestCare Treatment Services in Redmond, Oregon decreased the no-show rate for the initial intake appointment from approximately 40 percent to 25 percent in two different offices by waiving the fee for the initial intake appointment after learning that clients were not signing up for intake on the night of the orientation due to lack of money. The number of clients who scheduled intake appointments during orientation increased by 30 percent in the Bend office, and by 18 percent in the Redmond office. BestCare forecasts an additional 60 percent in revenue in the outpatient program from clients who come for a free initial intake appointment and continue in treatment. For further information, see BestCare's success story. <http://www.niatx.net/toolkits/provider/bestcare.pdf>

Genesis Behavioral Health in West Bend, Wisconsin increased copay collections from 45 percent to 92 percent and increased revenue from a budget deficit of \$13,000 in the first quarter of the year to a budget surplus of \$11,882 in the third quarter of the year by creating a tracking form to make it easier for counselors to track and collect copayments. Counselors met clients at the front desk with the tracking form to ensure that copayments were collected prior to the beginning of the session, instead of waiting until the end of the session. This change also increased continuation in treatment because they no longer were suspending clients because they didn't pay.

Billing as Part of Electronic Health Records

Electronic health records are coming to American medicine, in part because the government is offering incentives for adopting them. Billing can be part of such a system. This section will help you consider the value of an electronic system at your agency.

Electronic Medical Records: Frequently Used Terms

Electronic Medical Record (EMR): an individual's electronic record of health-related information. Authorized staff and clinicians within one healthcare organization can use the information.

Electronic Health Record (EHR): an individual's electronic record of health-related information in a form that meets national standards for interoperability. Authorized staff and clinicians from more than one healthcare organization can use the information.

Electronic Behavioral Health Record (EbHR): Just the same as the EHR (above), but for behavioral health information.

Electronic Practice Management (EPM): the part of the electronic health system that contains financial, demographic, and other non-medical information. Other terms used for this information include Enterprise Management System and Practice Management System.

Health Information Exchange (HIE): an electronic place for healthcare information from organizations within a community or region.

Health Information Technology (HIT): using computer hardware and software to store, retrieve, share, and use healthcare information to communicate and make decisions.

Interoperability: The ability of software and hardware on multiple pieces of equipment made by different companies to communicate and work together.

We'll use the term EHR in this section of the guide.

Financial benefits and costs of EHRs

Before investing in an EHR, ask yourself if the benefits you expect will exceed the costs you will incur. This section gives you a few billing-specific benefits and costs to consider.

To begin, ask system vendors to give you evidence about the improvements their system will produce. Ask for specifics—the setting, metrics, data collection, time horizon, analysis, and so on—so you can compare these improvements to what might be possible in your specific situation.

Financial benefits

EHRs produce savings mainly in administrative or business operations (billing) rather than in clinical operations (e.g., diagnosing, prescribing). For example, EHR vendors cite benefits such as fewer chart pulls; lower new-chart creation costs; reduced filing time, support staff, and transcription costs; and improved accounts receivable. The dominance of business and administrative benefits can pose a challenge in gaining support for a new system from clinicians—and their support is essential to the success of an EHR.

For billing, EHRs can increase coding accuracy and the number of services billed per client visit and make accounts receivable a more visible part of the agency. EHRs may also reduce:

- The accounts receivable period (the time between the service being delivered and the bill being paid)
- Bad-debt write off
- Billing overhead
- The cash-cycle period (the time between the service being delivered and the money received being paid to staff)
- Claim correction time
- Claim denial rate
- Coding time per client

How do EHRs actually produce these benefits? The answer: task re-allocation, automation, health information exchange (HIE), and interoperability. Most EHRs shift the responsibility of assigning codes from billing and coding staff to clinicians. Coding takes place during the client visit as the clinician enters information into the EHR rather than afterward. EHRs usually ease this process by offering drop-down menus that list illnesses, treatments, and prescriptions. The EHR assigns, stores, and transmits the appropriate diagnosis and treatment codes required for billing. This automation essentially eliminates the need for support staff to wade through paper charts to identify billable activity.

After a service has been rendered and coded, an agency may bill for the service the same day. Billing staff normally review the data entry and coding done by the clinician and in the EHR to confirm accuracy and then submit an electronic request for payment to the appropriate third-party payer through a secure health information exchange. Interoperability standards are important to the functioning of health information exchanges because the standards ensure that separate, standalone health information systems work together.

As clinicians document services rendered and support staff submit payment requests, the EHR's business module automatically generates and organizes revenue information. Various stakeholders may then review and use this information for different activities, such as managing accounts receivable and cash flow and

improving the revenue cycle. Most EHRs make it easy to create customized business and clinical reports that capture key performance indicators (KPI). For example, the single click of a mouse may show outstanding payment requests or denied claims, or calculate average accounts receivable. This feature of EHRs reduces or sometimes eliminates the costly task in paper-based systems of collecting, formatting, and presenting financial performance data.

Financial costs

The high cost of electronic health records presents the primary barrier to entry for most healthcare providers. You will want to figure out these costs, as well as when they will be incurred. The timing of the cost will influence your cost-benefit analysis and how you budget for the expense. The following list shows the main categories of expenses and examples of each.

- Hardware: personal computers (desktops, laptops, tablets), imaging (monitors, printers, scanners), servers (database, Citrix), security (high-capacity tape drives)
- Software: licenses (vendor, third party), server operating system licenses, electronic claims submission, integration (EHR & EPM), back-up software system/network monitoring software, integration with general ledger, virus protection, communication (e.g., MS Office, MS Outlook), firewall, upgrades
- Infrastructure and property: furniture (desks, chairs), office wiring (data, power), data center (closet, ventilation, power, uninterruptable power supply, racks), networking equipment (routers, switches), wide area connections to remote sites, back-up connections (DSL, cable), Internet connections
- Services: customization, training and re-training of current and future staff, user support, maintenance contracts, internal help desk (software supported), insurance
- Implementation labor: deciding, learning, analyzing, selecting, readying, planning, managing, designing, customizing, installing, testing, training, educating, supporting, upgrading, maintaining, certifying, improving
- IT labor: chief information officer (CIO), help desk support, EHR/EPM system analyst, PC/desktop support, network support, database administrator, report programmer
- Revenue loss: decrease in revenue incurred during implementation, when staff productivity dips

Non-financial benefits and costs

In addition to finances, EHRs also affect workflow and stakeholders. Understanding and addressing these “soft” issues is vital to the successful use of an EHR. If these issues are not addressed, agencies may experience staff resistance or exodus.

Workflow

The ingredients of workflow include: events (tasks, decisions, phases), resources (labor, documents, technology), relationships (sequencing), and information.

Implementing an EHR standardizes work flows. Standardization, or conforming to a norm, reduces workflow variation and errors by forcing the way things get done and who does them. In the context of billing, the EHR will determine who participates in the billing process; what decisions must be made and information collected during the billing process; and how and when the billing process starts and ends. Put another way, the EHR ensures that your agency bills the same way—always. This seems to be a positive change. But what if the way the EHR bills differs from the way you currently bill? Be sure to consider this last point thoroughly before you select an EHR.

To avoid selecting an EHR that staff will resist, choose one that best aligns with your agency's "ideal" work flows. An ideal workflow is how something should get done, not how something currently gets done. By defining ideal work flows, you'll improve the chance of making a successful EHR investment and, at the same time, reveal how much adaptation will be required from staff and by customizing the EHR. Small gaps between ideal and current work flows and an ideal versus actual EHR will require less adaptation, which leads to greater acceptance and lower implementation costs. The assessment tool that follows presents a framework for defining ideal, current, and EHR-based work flows.

People

The staff of your agency determines the quality of care delivered to clients. This makes it critical to involve staff in selecting an EHR and address up front the significant changes that will be required. For example, EHRs typically change how clinicians identify, frame, and solve problems; how clinicians diagnosis and treat illness; and how internal and external stakeholders communicate and coordinate activities. These differences result from how an EHR collects and shares information.

The job security of some staff may also be affected by adopting an EMR, constituting another consideration to weigh. Automated coding and electronic payment requests reduce the time required to bill payers. Oakwood Clinical Associates of Kenosha, Wisconsin, reported a 75 percent reduction in the time spent on billing. While the benefits of this reduction are clear, your staff may ask: "Will the EHR eliminate my job?" Address this question early. Otherwise fear and uncertainty will evolve into resistance and jeopardize your implementation strategy. To reinforce this point, consider the following quote by Peter Drucker: "Culture eats strategy for breakfast."

Assessment: Defining Current, Ideal, and EHR-based Processes

Complete the exercises sequentially with a multi-disciplinary team composed of internal and external (if possible) stakeholders. Exercise III must be done with the EHR vendor.

Exercise I—Current Billing Process: Start by asking the question, “What different billing processes exist within our agency today?” Next, apply the following questions to each separate billing process:

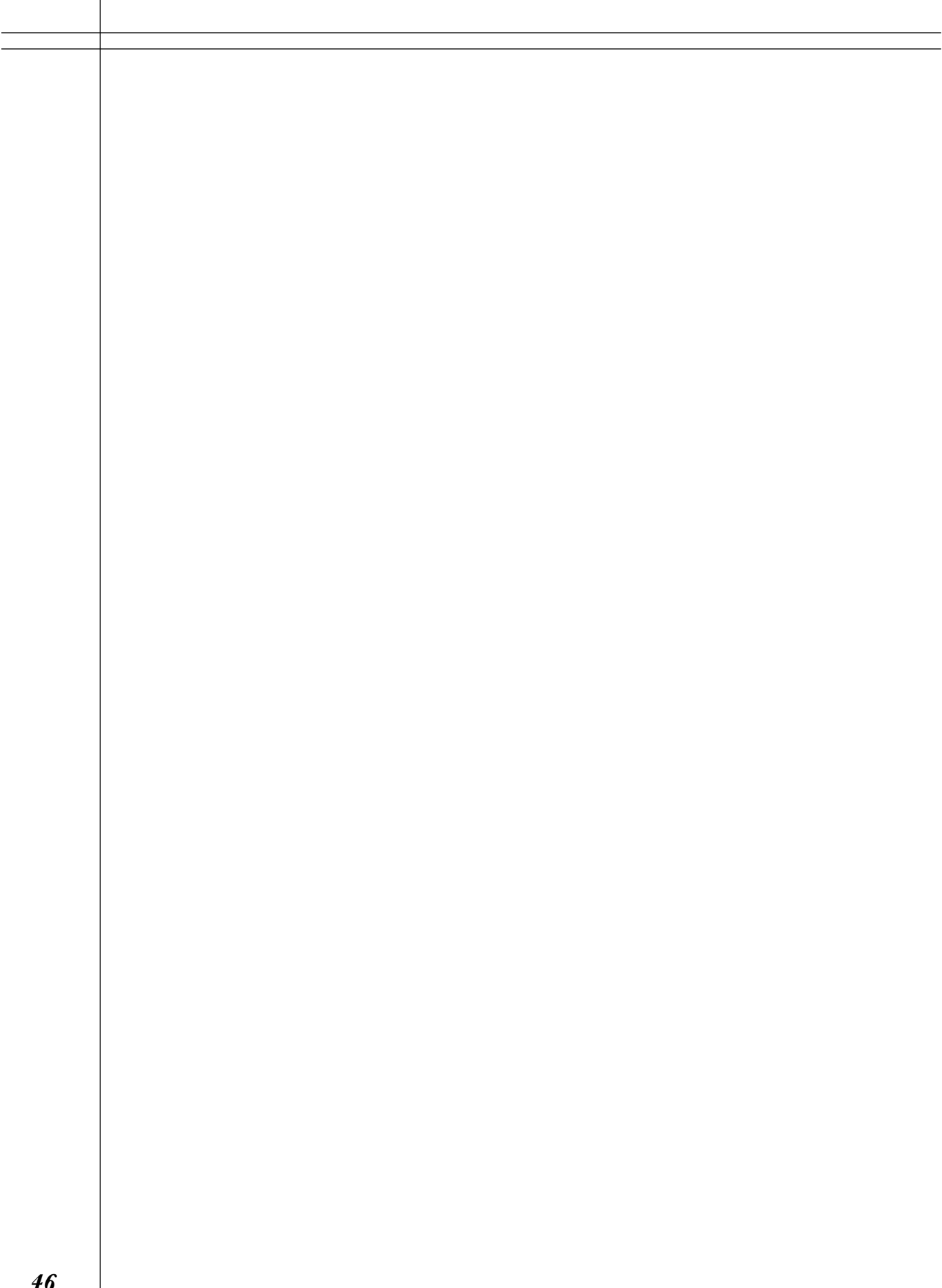
1. What is the objective or outcome of this process?
2. What event starts this process?
3. What event ends this process?
4. Who are the internal stakeholders of this process?
5. Who are the external stakeholders of this process?
6. What inputs does each stakeholder provide during this process?
7. What outputs does each stakeholder collect during this process?
8. How do we measure the performance of this process?
9. What problems or errors does this process encounter consistently?

Exercise II—Ideal Billing Process: Start by asking the question, “What different billing processes would we prefer within our agency?” Next, apply the following questions to each separate billing process:

1. What is the preferred objective or outcome of this process?
2. What event would we prefer start this process?
3. What event would we prefer end this process?
4. Who would we prefer as internal stakeholders of this process?
5. Who would we prefer as external stakeholders of this process?
6. What inputs would we prefer each stakeholder provide during this process?
7. What outputs would we prefer each stakeholder collect during this process?
8. How would we prefer to measure the performance of this process?
9. What problems would this process encounter consistently?

Exercise III EHR—Billing Process: Start by asking the question, “What different billing processes does this EHR offer?” Next, apply the following questions to each separate billing process:

1. What is the objective or outcome of this EHR-based process?
2. What event starts this EHR-based process?
3. What event ends this EHR-based process?
4. Who are the internal stakeholders of this EHR-based process?
5. Who are the external stakeholders of this EHR-based process?
6. What inputs does each stakeholder provide during this EHR-based process?
7. What outputs does each stakeholder collect during this EHR-based process?
8. How can we measure the performance of this EHR-based process?
9. What problems or errors will this EHR-based process encounter consistently?



Conclusion

NIATx developed the NIATx Third-party Billing Guide to help substance abuse treatment providers prepare for the changes that healthcare reform and parity legislation will bring. Because every treatment agency is unique, you will develop a system for billing third-party payers that's tailored to your needs. We hope that you find this guide helpful and welcome your feedback. Please send comments and suggestions to:
maureen.fitzgerald@chess.wisc.edu

About NIATx

NIATx helps payers and behavioral healthcare providers remove barriers to treatment and recovery. We serve people facing the challenges of addiction and/or mental health disorders by making improvements to the cost and effectiveness of the care delivery system. The simple and easy to use process improvement model we developed specifically for behavioral healthcare allows payers and providers to make small changes that have a significant impact on outcomes.

As a learning collaborative within the University of Wisconsin–Madison's Center for Health Enhancement Systems Studies, we provide research, promising practices, and innovative tools that encourage and support the use of the NIATx model.

Glossary

Accounts payable: money a company owes to its creditors

Accounts receivable: money that a client owes you

Accrual-based accounting: the most commonly used accounting method, which reports income when earned and expenses when incurred (investorWords.com)

Aging schedule: a list of accounts receivable broken down by the number of days until due or past due. (investorWords.com)

Balance sheet: a statement of the assets, liabilities, and capital of a business or other organization at a particular point in time, detailing the balance of income and expenditure over the preceding period (*New Oxford American Dictionary*)

Block grant: a grant from a central government that a local authority can allocate to a wide range of services (*New Oxford American Dictionary*)

Copay: a payment owed by the person insured at the time a covered service is rendered. (*New Oxford American Dictionary*)

Contractual allowance: The difference between what an insurance company approves according to their contract and what the healthcare provider charges for the procedure. If the provider is under contract to accept the patient's insurance plan, the patient is generally not responsible for this difference. A contractual allowance shows up on a billing statement as an adjustment required and decreases the balance.

CPT® Codes (Current Procedural Terminology): Current Procedural Terminology codes, also known as CPT® Codes, is a set of five-digit codes used to describe the medical, surgical and diagnostic services done. CPT codes allow physicians, patients, counsel, insurance companies and others to communicate effectively throughout the U.S.

Deductible: Specified amount of money that the insured must pay before an insurance company will pay a claim (*New Oxford American Dictionary*)

Explanation of Benefits (EOB): A statement a health insurance company sends to a member listing services that were billed by a healthcare provider, how those charges were processed, and the total amount of patient responsibility for the claim.

Fee-for-service: Providers are paid a specified amount for each service provided

Generally Accepted Accounting Principles (GAAP): A collection of rules and procedures and conventions that define accepted accounting practices. Organizations typically use GAAP when setting up a billing system.

Managed care: Managed care plans are health insurance plans that contract with healthcare providers and medical facilities to provide care for members at reduced costs. These providers make up the plan's network. How much care the plan will pay for depends on the network's rules.

There are three types of managed care plans:

- Health Maintenance Organizations (HMO) usually only pay for care within the network. A member chooses a primary care doctor who coordinates most of the care.
- Preferred Provider Organizations (PPO) usually pay more if the member gets care within the network, but they still pay a portion if the member goes outside.
- Point of Service (POS) plans let the member choose between an HMO or a PPO each time he/she needs care.

(Source: <http://www.nlm.nih.gov/medlineplus/managedcare.html>)

Out-of network provider: A provider or facility that does not have a contract with the patient's insurance company

Panel, panelling: Treatment provider organizations and individual clinicians who become credentialed with a third-party payer are then considered to be on the payer's "panel," or group of organizations and clinicians approved to bill for services rendered.

Prior authorization: A cost containment measure that provides full payment of health benefits only if the hospitalization or medical treatment has been approved in advance. Sometimes called pre-authorization or prior approval

Third-party payer: An organization other than the patient (first party) or healthcare provider (second party) involved in the financing of personal health services.
(<http://medical-dictionary.thefreedictionary.com>)

Utilization management: Techniques to manage the cost of healthcare before it is provided; may involve case-by-case assessments of the appropriateness of care based on accepted practices. (<http://medical-dictionary.thefreedictionary.com>)

Utilization review: a review of the necessity, use, appropriateness, efficacy or efficiency of healthcare services, procedures, providers, or facilities.



Appendix

Case Studies

- Creating a Billing System: San Mateo County
- Life cycle of a bill at SSTAR
- Decrease denials and increase collections: Fayette Companies
- Increasing contracts with third-party payers: MECCA Services
- Implementing an Electronic Medical Record: Oakwood Associates

Standard billing forms

- CMS 1500
- HCFA 1500
- UB-04

Sample forms

- Billing policy and financial agreement
- Daily charges
- Fee schedule
- HMO benefits maxed
- Insurance authorization tracking worksheet
- Insurance verification form

Useful resources

- American Medical Association:
<http://www.ama-assn.org/ama1/pub/upload/mm/368/15questions.pdf>
- The American Medical Billing Association: <http://ambanet.net/AMBA.htm>
- Healthcare Billing & Management Association: <http://www.hbma.org/>
- Health Information Privacy: <http://www.samhsa.gov/healthPrivacy/>
- Medical Association of Billers: <http://www.e-medbill.com/>
- National Uniform Claim Committee:
http://nucc.org/images/stories/PDF/claim_form_manual_v5-0_7-09.pdf
- The NIATx Provider Toolkit:
<http://www.niatx.net/Content/ContentPage.aspx?PNID=2&NID=16>
- United Behavioral Health Level of Care Guidelines:
<https://www.ubhonline.com/html/guidelines/levelOfCareGuidelines/index.html>

Case Study: Creating a Billing System in San Mateo County

Behavioral Health and Recovery Services (BHRS) is the county agency that provides substance abuse treatment and mental health services for children and adults in San Mateo County, California. Clara Boyden, AOD Program Manager for BHRS, is no stranger to the NIATx model. In a previous project, she and her team used NIATx techniques to promote countywide improvement and build the agency's capacity to serve clients. When NIATx announced the first Business Practices for the Future Learning Collaborative (2010-2011), Clara was eager to get involved. BHRS served as the "convener" for the San Mateo County collaborative, recruiting 11 of its contracted agencies to learn how to bill third-party payers.

"San Mateo County providers have little or no experience or infrastructure for billing outside of the federal block grant," she explains. Most had not billed any other entity other than the county. "Since the county doesn't have the coding or documentation requirements that commercial payers do, we really had to start from the ground up," says Clara.

Obtaining NPI numbers

Many of the providers had to apply for the NPI number, since it had not been required in the past for the federal SAPT block grant or the dedicated state and local funding stream for services.

"We offer psycho-education. Is that billable?"

This group of providers began by determining which of their services are actually billable. Adds Clara, "Many services evolved from the community and were started by people in recovery. They needed to think of their agencies in terms of a therapeutic perspective."

One of the first activities for the group was to examine how the services they offer match the CPT (Current Procedural Terminology) and ICD9 (International Statistical Classification of Diseases and Related Health Problems) diagnosis codes. They worked on re-thinking the descriptions and definitions for their programs so they fit the CPT codes.

Changing language and culture

This group of providers is learning to speak about the work and the services that they provide using the language that a medical insurance provider would recognize as a therapeutic service or an evidence-based practice.

"It's really like learning a new language," explains Clara. To help with learning this new language, the group created a dictionary of billing codes used most frequently in behavioral health, with descriptions of the services they represent.

Credentialing requirements

In California, treatment agencies eligible for block grant funding only require staff with a two-year AODA certificate to deliver treatment services. Private insurance companies have more stringent licensing requirements for who can deliver billable services.

“These small community-based programs have few licensed staff and have limited resources to hire licensed staff,” says Clara. Only two-thirds of the providers in the San Mateo collaborative have licensed staff. “We found that determining patient coverage is fairly straightforward process, but requesting prior authorization from a third-party payer is a challenge if the program does not have staff that meet the payers’ licensing requirements,” says Clara.

To overcome this challenge, the group is checking to see if third-party payers will approve services if a licensed staff member oversees the work of another staff member who is AODA-certified. They are also working on finding cost-effective ways for existing staff to obtain the required licensing.

Adds Clara, “At the same time, these providers also need to consider whether third-party reimbursement rates will generate the revenue they need to pay licensed staff.”

Having licensed staff is also an issue in considering Medi-Cal, California’s Medicaid program, as a revenue source. “Most providers have not pursued this because it requires a physician to review all treatment plans. And Medi-Cal’s low reimbursement rate would not justify hiring a physician.”

Documentation requirements

The San Mateo providers were accustomed to providing the clinical documentation needed for reimbursement from the county. “County requirements are not as rigorous as a typical third-party payer’s,” explains Clara. “We’ve been working on learning to record services rendered appropriately, so they have supporting documentation if an insurer questions whether an authorized service was indeed billable.”

Forming a network

These challenges have triggered providers to explore the possibility of forming a network that could attract large third-party payers. The 11 agencies combined have the cultural and linguistic abilities to meet the needs of an underserved and diverse population that includes Latinos, Asian Americans, and Pacific Islanders.

Concludes Clara, “By collaborating and sharing staff, resources, this group hopes to build its capacity to participate fully in third-party billing.

The Life Cycle of a Bill at SSTAR

Stanley Street Treatment and Resources (SSTAR) is a non-profit healthcare and social service agency that provides a wide range of mental health and substance abuse treatment services to people throughout the communities of Southeastern Massachusetts and Rhode Island. SSTAR accepts Medicare, Medicaid, and most third-party insurance plans.

Intake

SSTAR staff complete 90 percent of the intake process over the phone, asking a series of questions that include: name, type of addiction, contact and insurance information, and whether or not the caller has been a client before. This information is entered into the agency database, called "Hill." The person doing the intake also checks the client's insurance information against the state's Department of Health and Human Services database, which is available to contracted providers such as SSTAR.

If this is a client's first appointment, we enter the service we expect to provide into the database. The service appears as an asterisked item on the documentation used for billing ("Superbill").

"Clinician not billable by pay source" is one of the primary reasons third-party payers reject payment requests. To minimize billing/collection problems, we schedule clients with a clinician whose credentials match the third-party payer's requirements.

First-time clients and those returning after their case had previously been closed are scheduled for an orientation. The orientation has several objectives, one of which is to fill out the various releases required by the state.

Insurance Verification

Our intake staff shares office space with the individual doing insurance verification. This facilitates a free exchange of information during the early stages of client contact, and minimizes billing errors.

Our insurance verification process consists of:

- Checking the client's eligibility on the insurance company's database
- Determining the number of sessions authorized, the number of sessions used, and the number of sessions available
- Establishing the client's policy number
- Reviewing the client's service type coverage
- Obtaining the initial authorizations from the insurance company

This process allows us to identify problems that may result in denial of payment. If a problem is uncovered, even a minor one, we phone the insurance company to resolve it.

Client Appointment

We create and introduce the “Superbill” to a client’s file when we schedule them for an appointment. Our Superbill is a pink, multi-copy, one–page document that contains all of the information needed to bill the payer. It is populated using data previously entered into the agency’s database and holds the client’s information as well as clinician information. It also outlines a client’s ability or inability to pay the copay or deductible cost.

Although scheduled services are pre-populated and marked with an asterisk, the Superbill also includes a checklist of all the services we offer. This allows the clinician to check items off as needed. After the session, the clinician “checks” the services provided. These services should match the automated asterisk next to the anticipated services for the session. The clinician can check a service other than the one asterisked, but this change must be accounted for on the Superbill. The clinician also notes the next scheduled appointment. The clinician places the Superbill in a bin where a clerical staff person retrieves it. That person then enters service information into Hill and follow-up appointments into Outlook, our scheduling software.

At this point, an administrator reviews the Superbill in Hill. That person corrects any service changes, no shows, or cancelled appointments, and “renders” the transaction. Rendering is the software vendor’s terminology for allowing the agency to invoice the payer. The software pulls our standard or usual dollar value for that service from a master list (labeled “usual”) and prints it alongside the payer’s standard payment for that service (labeled “expected”).

As an additional check to minimize errors on the Superbill, we print a monthly productivity report for each clinician. Our clinicians then verify that the service rendered in the report was the service provided to the client.

Open the Chart

Once we have rendered a transaction, we “open the chart.” Opening a chart is the way we gather and separate all of the paperwork we have generated. We arrange them in a three-hole binder labeled with the client’s name and intake identification number.

The chart includes:

- All releases and consent forms
- Substance Abuse clients include a “Medicaid Reimbursable” form
- Intake sheet
- Insurance sheet
- Picture ID
- Superbill
- “Virtual Gateway” documentation (The State web portal requires that information be re-entered on-line)

We enter the clinical record into a separate database called "SATIS," the Electronic Health Record. Clerical and/or intake staff enter intake and demographic information, while clinicians enter all of their clinical notes. The record includes the clinician's name, the diagnosis, the date of service, whether domestic violence was involved, and the referral source.

Billing

Once we have done all of our checks for errors and rendered the Superbill, we can bill the third-party payer. At this point, the billing clerk runs a report that checks for fatal errors and potentially problematic invoices, by insurance company. We cannot bill third-party payers until all errors are fixed. Primary invoice problems include:

- Previously approved authorization is missing
- Clinician is not billable by the pay source
- Other missing documentation

Some third-party payers allow electronic billing. To accomplish this, the clerk runs a "billing schedule" which batches all claims ready to be billed, both inpatient and outpatient, by insurance company. We transfer this to a disc that is loaded onto the insurance company's website. The website supplies a confirmation of receipt.

Approximately 70 percent of our billing is electronic. The remaining 30 percent of payers have no electronic data interchange. We bill these payers by paper.

Case Study: Decrease Denials and Increase Collections, Fayette Companies

Fayette Companies is a behavioral health organization located in Peoria, Illinois. With 17 sites across Peoria County, Fayette Companies provides services for people with serious mental illness, substance use disorders, and co-occurring disorders.

Among the first organizations to implement NIATx techniques as a participant in the Paths to Recovery pilot project, Fayette Companies made dramatic improvements in access and retention—and the agency’s bottom line. Since then, NIATx has become part of the organization’s way of doing business.

Fayette Companies earns the majority of its revenue from state contracts, but has also been contracting with third-party payers for over 20 years. In 2008, David Moore, vice president of quality improvement, identified a problem: third-party payer denials were high—and getting higher—and collections were dropping. “I realized that we needed to change our culture and systems to bill effectively with third-party payers,” says Moore.

When he took a closer look at the denials and collections, Moore recognized that the way Fayette Companies addressed contracts and credentialing had become fragmented and decentralized. For example, the agency had nearly lost a preferred provider contract with a large managed care organization (MCO) simply because they’d neglected to re-credential.

“Different people in the organization were dealing with contracts at different times, and we had not established any goals or metrics,” explains Moore.

Another system that needed attention was the front door process for checking benefits. “It was hit or miss at best,” says Moore. “Because we have a mix of state funding and third-party private payers, we had to make certain that the process for determining eligibility was much more accurate.”

Plus, there was little communication between the staff responsible for benefit checks and prior authorizations and staff responsible for the billing and collections. “These two silos were not talking to each other to discuss what we could do at the front door to avoid denials.”

Moore and his change team then set about gathering baseline data, identifying metrics, and establishing benchmarks for four areas: contracts and credentialing; benefits, pre-certifications, and re-authorizations; billing; collections and denials.

Contracts and Credentialing

“We first had to figure out what contracts we already had, when we could renew them, and when we could renegotiate rates.” The team also came up with uniform fees to set for all contracts and a system for gaining new contracts.

Benefits, Pre-Certifications and Re-Authorizations

The team used NIATx process improvement techniques to implement a new policy to verify benefits and request pre-certifications and reauthorizations.

Billing

Moore's team reviewed Fayette Companies' fee policy to make sure that fees were covering costs. Adds Moore, "All organizations will have to continue to review their fee policy regularly and revise it to address the changing reimbursement landscape."

Collections and Denials

The key was to get the staff members doing benefits verification, pre-certifications, and reauthorizations together in the same room with the staff handling collections and denials. "Together, they worked out a way to change the way we view financial documentation at the front door as well as on-going clinical documentation throughout the treatment episode," explains Moore.

The results of these changes? "We have been gaining revenue from appealing denials. The numbers add up quickly," says Moore. "We have also added new MCO contracts and have more staff credentialed with existing contracts."

Moore recommends this approach to other treatment organizations that want to reduce their third-party payer denials and increase collections. "By using the NIATx model—taking baseline data and setting goals—we have continued to improve our collections and lower our rate of denials. Our approach to managing third-party private contracts is completely different today."

Case Study: MECCA Services Adds Contracts with Third-Party Payers

MECCA Services offers substance abuse and behavioral health services at eight locations in central IOWA. Like Fayette Companies, MECCA was among the first organizations to adopt the NIATx model to improve access to and retention in treatment, as a grantee in the Paths to Recovery Program. Since then, process improvement has become part of MECCA's culture. The agency participated in the first NIATx-SI Business Practices for the Future Learning collaborative, and focused on adding contracts with third-party payers.

"We're looking ahead to the changes expected in 2014 and wanted to improve our ability to bill third-party payers by increasing contracts, says Ron Berg, CEO.

When the collaborative launched in October 2010, MECCA had just a few formal contracts with third-party payers, but lots of experience billing through single case agreements. Working with Chris Auner as the project change leader, Berg set a goal to negotiate a contract with at least one third-party payer by the end of the ten-month collaborative. He focused on Mecca's Synchrony program, which was created specifically to provide EAP services for area businesses.

"All of the Synchrony staff are either licensed as mental health counselors or independent social workers," says Berg. "We found that clients referred to us through an EAP often developed a therapeutic relationship with a counselor and wanted to continue after the four or five sessions covered by the EAP."

However, because MECCA had only a facility contract with Wellmark Blue Cross and Blue Shield (the payer covering the EAP benefit), clients who wanted to continue to see a particular Synchrony counselor would have to pay a deductible of \$500 to \$1,000, depending on their particular plan benefit design.

"We were losing clients because of that high deductible," says Berg. "We learned that if we could credential our counselors individually with Wellmark, clients would only have to pay a small copay of \$10.00-\$15.00."

Wellmark was very receptive to establishing contracts with the four individual counselors. They completed the required paper application forms, rather than using a credentialing clearing house.

"We learned a lot about how to submit the credentialing paperwork and were able to apply what we learned when we worked on a contract with a second payer—Priority Health Network," says Berg. He anticipates that the contracts will increase revenue for the Synchrony program. "We can now accept clients from any referral source and be on the same footing as other individual providers in the area", says Berg, adding that this also removes a barrier to treatment and improves customer service.

Because all prior payments to Synchrony had been as a facility, Berg had to make adjustments to the billing process. This included switching to the CMS 1500 billing form. His team recently submitted their first successful claim for a service they had not been able to bill for in the past.

The NIATx principals helped focus this project to prepare for a new funding environment, says Berg. “Our customers said that they wanted to continue services at Synchrony but the deductible was too big. So this project definitely sought to understand and involve the customer.” He and Auner also looked outside the field: “We looked to the for-profit organizations for ideas and inspiration. “

Berg’s lesson to other organizations seeking to increase their contracts with third-party payers? “Having contracts with third-party payers for individual counselors as well as a facility contract gives you more options for seeking reimbursement.”

Case Study: Implementing an Electronic Medical Record, Oakwood Clinical Associates

About Oakwood Clinical Associates

Oakwood Clinical Associates in Kenosha, Wisconsin offers comprehensive outpatient mental health and substance abuse counseling to residents of Kenosha County and the surrounding area. With a staff of 17, including 12 clinicians, Oakwood Clinical Associates provides an average of 1,000 counseling sessions per month.

Implementing an Electronic Medical Record

Director Amy Anderson started to consider implementing an electronic medical record (EMR) in late 2008. “I was tired of paper charts—finding them, delivering them, collecting and re-filing them. And the time seemed right to prepare for the possible mandate of EMR as part of healthcare reform.”

Oakwood Clinical Associates has built a culture of process improvement, having participated in the NIATx-sponsored Strengthening Treatment Access and Retention-State Implementation project. The NIATx model gave the Oakwood staff a new appreciation for data. “Before collecting and looking at data, we weren’t aware of no-show rates, continuation rates, and wait times. We were aware that we were losing potential revenue. With EMR, data for these measures is instantly accessible.”

Changes Implemented

Amy began to gather information about the various models available, and decided that a fully integrated product would be best for Oakwood. “A fully integrated system allows us to capture information for all the processes, from patient demographics, billing and insurance to the entire clinical record—assessment to discharge documentation.”

Oakwood selected an integrated EMR system that offers a specialty template for behavioral health. “It also allows us to customize our preferences to coordinate care with primary care physicians,” adds Amy.

Amy appointed one staff member to lead the implementation process. “The vendor will give you a detailed plan for implementation, but you have to make sure you can dedicate staff and resources to the effort.”

Two smaller groups worked on customizing the system. Members of the office staff focused on patient demographic, billing and scheduling functions; two members of the clinical team customized the clinical templates. These teams then trained the rest of the Oakwood staff. Implementation began on March 31, 2009, with full “go live” on October 20, 2009.

Once the software was installed, the Oakwood team used NIATx tools such as flowcharting,

the walk-through exercise, and requesting customer feedback to identify areas for improvement.

Results

The EMR has increased efficiency at Oakwood, particularly for the intake and billing processes. “Patients complete intake on their own using a computer in the waiting room, and that record is merged immediately into the assessment document,” explains Amy. “And we’ve eliminated paper charts!”

Other benefits that Amy cites include greater consistency in documentation and having data at your fingertips. “We can see no-show data or time from first call to first appointment immediately—there’s no need for separate tracking.”

Lessons Learned

Switching from paper to electronic medical records was not without its trials, adds Amy. “The anxiety was pretty high, especially for clinicians who were not accustomed to using computers for patient records. We also have some patients who are not computer literate who can’t complete intake on the computer.”

Amy’s advice to other providers who are planning to switch to an EMR? “Do a gradual phase in of electronic records and a gradual phase out of paper. We made the switch overnight and that caused a lot of stress. Thank goodness we have a resilient staff who made the change successfully! ”

Promising Practice for Implementing an Electronic Medical Record

At Oakwood, the transition to an EMR was a source of stress for clinicians who were accustomed to doing most of their work on paper, using a computer only for e-mail. The immediate change in standard practices presented a steep learning curve, making it difficult for clinicians to see the same number of clients. The extra time required to learn new documentation practices is best spread out over several months.

Standard Billing Forms

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA										PICA																								
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)														
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)														
CITY					STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										CITY					STATE									
ZIP CODE					TELEPHONE (Include Area Code) ()					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										ZIP CODE					TELEPHONE (Include Area Code) ()									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER														
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME														
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME														
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>														
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																								
14. DATE OF CURRENT: MM DD YY					ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					17b. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY														
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____														
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 2. _____ 3. _____ 4. _____										23. PRIOR AUTHORIZATION NUMBER _____																								
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #														
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2																																		
3																																		
4																																		
5																																		
6																																		
25. FEDERAL TAX I.D. NUMBER					SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. BALANCE DUE \$				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH # () a. NPI b. _____														

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, AS CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used the hospital doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128BB of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

PLEASE DO NOT STAPLE IN THIS AREA



CARRIER

HEALTH INSURANCE CLAIM FORM

PICA [] [] [] PICA [] [] []

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>
CITY STATE	7. INSURED'S ADDRESS (No., Street)
ZIP CODE TELEPHONE (Include Area Code) ()	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
a. OTHER INSURED'S POLICY OR GROUP NUMBER	11. INSURED'S POLICY GROUP OR FECA NUMBER
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
c. EMPLOYER'S NAME OR SCHOOL NAME	b. EMPLOYER'S NAME OR SCHOOL NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	c. INSURANCE PLAN NAME OR PROGRAM NAME
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN
19. RESERVED FOR LOCAL USE	20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>	28. TOTAL CHARGE \$
29. AMOUNT PAID \$	30. BALANCE DUE \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)
	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

1		2		3a PAT. CNTL. #		4 TYPE OF BILL	
				b. MED. REC. #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM	
						7 THROUGH	

8 PATIENT NAME		a		9 PATIENT ADDRESS		a	
b		b		c		d	
e							

10 BIRTHDATE		11 SEX		12 DATE		ADMISSION 13 HR		14 TYPE		15 SRC		16 DHR		17 STAT		18		19		20		21		CONDITION CODES 22		23		24		25		26		27		28		29 ACDT STATE		30	
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31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 CODE		OCCURRENCE SPAN FROM		THROUGH		36 CODE		OCCURRENCE SPAN FROM		THROUGH		37	
a		a		a		a		a		a		a		a		a		a		a	
b		b		b		b		b		b		b		b		b		b		b	

38		39 CODE		VALUE CODES AMOUNT		40 CODE		VALUE CODES AMOUNT		41 CODE		VALUE CODES AMOUNT	
a		a		a		a		a		a		a	
b		b		b		b		b		b		b	
c		c		c		c		c		c		c	
d		d		d		d		d		d		d	

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
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17							17
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PAGE ____ OF ____		CREATION DATE		TOTALS			

50 PAYER NAME		51 HEALTH PLAN ID		52 REL. INFO		53 ASG. BEN.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	
A		A		A		A		A		A		A	
B		B		B		B		B		B		B	
C		C		C		C		C		C		C	

58 INSURED'S NAME		59 P. REL.		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.	
A		A		A		A		A	
B		B		B		B		B	
C		C		C		C		C	

63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
A		A		A	
B		B		B	
C		C		C	

66 DX		67		A		B		C		D		E		F		G		H		68	

69 ADMIT DX		70 PATIENT REASON DX		a		b		c		71 PPS CODE		72 ECI		a		b		c		73	
74 PRINCIPAL PROCEDURE CODE		DATE		a. OTHER PROCEDURE CODE		DATE		b. OTHER PROCEDURE CODE		DATE		75		76 ATTENDING NPI		QUAL		LAST		FIRST	
c. OTHER PROCEDURE CODE		DATE		d. OTHER PROCEDURE CODE		DATE		e. OTHER PROCEDURE CODE		DATE				77 OPERATING NPI		QUAL		LAST		FIRST	

80 REMARKS		81CC a				78 OTHER NPI		QUAL		LAST		FIRST	
		b								79 OTHER NPI		QUAL	
		c								LAST		FIRST	
		d								LAST		FIRST	

UB-04 FRONT

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
 - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
 - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
 - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
 - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
 - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
 - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
 - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
 - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

SEE <http://www.nubc.org/> FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

Sample Forms

Client Name: _____

Date: _____

Billing Policy & Financial Agreement

FEE SCHEDULE:

Outpatient Services	MD	Therapists
Court Evaluation	N/A	\$300-\$400
Initial Evaluation (1 hour)	\$300	\$175-\$300
Medication Check (15 min)	\$90	N/A
Individual Sessions (1/2 hour - 1 1/2 hours)	\$150-\$250	\$70-\$250
Family Sessions (1 hour)	N/A	\$175-\$250
Group Sessions (1 hour - 1 1/2 hours)	N/A	\$70-\$90

- A 10% discount will be given to all self-pay clients who pay in full on the date of service. All fees for dates of service not paid the same day will be billed out at the regular rate.
- A 10% discount will be given to all self-pay clients who have a credit card agreement on file to pay the balance in full every month, please contact the billing department for more information.

CANCELLATION/NO-SHOW POLICY FOR PSYCHIATRISTS AND THERAPISTS:

Provider requires all clients to give a 24-hour business day notice should they need to cancel or reschedule to avoid charges. If you do not give a 24-hour business day notice to cancel an appointment or simply do not show up for an appointment, you will be billed at the full session fee starting with the first missed appointment. All no-show/late-cancel fees need to be paid on or before the next scheduled appointment. Please keep in mind failure to follow the above policy may compromise services at Provider. Late-cancel/no-show fees cannot be billed to insurance.

Initials

RETURN CHECK POLICY:

Checks returned for insufficient funds will be charged to you at \$ 50.00 plus any additional bank charges.

FINANCIAL INFORMATION:

How will you be paying for services? Insurance Cash/Check Credit Card Fee For Service

Sample Daily Charges Form

Therapist: Joe Smith Page 1 of _____

Day of Week: Tuesday Date: 5/18/10

#	APPT TIME	NAME (Last, First)	DX Code (if new/changed)	CPT Code	Charge (if not standard)	X (if pd same day)
1	4	Doe, Jane		90806		
2	6	Doe, John		99949-LC	No Charge	
3						
4						
5						
6						
7						
8						
9						
10						
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12						

CPT Codes

90801=Initial Evaluation

90804=25-30 min therapy

90805=25-30 min med ck w/ therapy

90806=45-50 min therapy

90807=45-50 min med ck w/ therapy

90808=75-80 min therapy

90809=75-80 min ck w/ therapy

90846=family therapy w/o patient

90847=family therapy w/patient

90853=group (please indicate minutes after CPT code)

99949=no show/late cancel

*99998=miscellaneous - how many units=\$10 per unit/10% discount not given,

*note 99998 can be used for court evals

Special Billing Instructions:

Sample Fee Schedule

Psychiatrist	CPT Code	Time	Full Price	10% discount
Initial Evaluation	90801	60 minutes	\$300.00	\$270.00
Medication Check	90862	15 minutes	\$90.00	\$81.00
Psychotherapy w/ Medication Review	90805	20-30 minutes	\$150.00	\$135.00
Psych w/ Med Review	90807	45-50 minutes	\$200.00	\$180.00
Psych w/ Med Review	90809	75-80 minutes	\$250.00	\$225.00

Therapists	CPT Code	Time	Level I	Level II	Level III	10% discount
Initial Evaluation	90801	60 min	\$250.00	\$200.00	\$175.00	\$225.00/ 180.00 157.50
Psychotherapy	90804	20-30 min	\$100.00	\$80.00	\$70.00	\$90/72.00/ 63.00
Psychotherapy	90806	45-50 min	\$200.00	\$150.00	\$130.00	\$180/135.00/ 117.00
Psychotherapy	90808	75-80 min	\$250.00	\$210.00	\$180.00	\$225.00/ 189.00/ 162.00
Group Therapy	90853	60 min		\$70.00		\$63.00
Group Therapy	90853	90 min		\$90.00		\$81.00
Family Therapy	w/client: 90847 w/o:90846	60 min	\$250.00	\$200.00	\$175.00	\$225.00/ 180.00 157.50
Court Evaluation	-----	variable	\$300.00	\$300.00	\$250.00	\$270.00/ 270.00/ 225.00

*** 10% Discount**

A 10% discount will be given to self-pay clients who pay in full on the date of service. Also a 10% discount will be given to self-pay clients who have credit card on file with the accounts manager and the entire balance is paid in full at the end of every month.

*** Payment Plans**

All payment plans need to be set up with the accounts manager.

***Late-Cancel/No-Show Appointment Policy**

All appointment cancellations require a 24-hour notice. Late-cancel/No-show fees are billed at the full session price and are to be paid on or before your next scheduled appointment.

(COMPANY LOGO) Insurance Authorization Tracking Sheet

Client Name: _____ DOB: _____

Date: _____ Primary Therapist: _____

Other Therapists Involved: _____

Insurance: _____ Visit Limit/Max Benefit Paid: _____

Visits Authorized: _____ Authorization Dates: _____

Visits Used Elsewhere/\$ Amount Used Elsewhere: _____

Date Visits Maxed for Calendar Year/Plan Year: _____

Date Maxed Letter Sent: _____

Visit#	Date	Txpist	CPT code	Charge	Actual#/\$	Notes:
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SAMPLE INSURANCE VERIFICATION FORM

Client Name _____	Chart # _____
Soc Sec # _____	

Insurance Co. Name: _____		
Phone: _____	Name of Contact: _____	Date: _____
Policy # / RID: _____	Employer: _____	
Policy Holder Name, if not self: _____	Policy Holder DOB: _____	
Policy Holder Social Security # _____	Policy Holder Relation to Patient: Self Spouse Parent Child Other	

OUTPATIENT SUBSTANCE ABUSE/MENTAL HEALTH BENEFITS

Effective Date of Policy: _____

Does patient have a deductible?: Yes No If Yes, what amount \$: _____ Per: _____ Has it been met? Yes No

Maximum number of sessions allowed: Per Year: _____ Per Lifetime: _____

If there is a maximum number of sessions allowed, how many have been used so far this benefit period? _____

Is there a maximum amt of \$ per calendar Yr that the Ins co. will pay: _____ Has the client used this maximum amount? Yes No

Does the client have a copay or co-insurance or any other out-of-pocket expenses with this insurance company: Yes No

If yes, what is it, and what is the amount?: _____

Primary Care Physician: _____ Telephone: _____

Address: _____

AUTHORIZATIONS

Intake Individual Group Psych	Dates covered: _____	# of Sessions: _____
	Auth number _____	
Intake Individual Group Psych	Dates covered: _____	# of Sessions: _____
	Auth number _____	
Intake Individual Group Psych	Dates covered: _____	# of Sessions: _____
	Auth number _____	

Insurance Claims Submission Address: _____

Secondary Insurance Name, If any: _____

Policy # RID: _____ Employer/Group: _____

Policy Holder, IF different from Clients name: _____



REMOVING BARRIERS *to* Treatment & Recovery

We serve people facing the challenges of addiction and/or mental health disorders by improving the cost and effectiveness of the care delivery system.

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Mechanical Engineering, Room 4121
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E-mail: info@NIATx.net
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