Getting Paid

A common complaint from psychiatrists is that managed care companies (MCOs) are slow to pay their claims or don't pay them at all. The following suggestions will increase the likelihood of having your claims paid quickly and correctly. They will help you avoid the common mistakes that cause claims to be denied, delayed due to rerouting, or even misdirected and lost.

AUTHORIZATION NUMBERS

Since some contracts leave the ultimate responsibility for preauthorizations with the physician rather than with the patient or the MCO, and since it is always the physician's responsibility to verify that the preauthorization process has been completed, you might just want to do the authorizations yourself for all your patients. This way you'll know you are getting the correct information, and it is more likely you'll be reimbursed properly, because should you treat a patient who has failed to register care, you will not be able to collect payment from the patient's insurance carrier (or the carrier might pay at a very low "noncompliance" rate). If you are an in-network provider, you will have to write off the expense, and the patient will be held harmless.

If, for whatever reason, you feel it is not possible for your office to do preauthorizations for your patients, then just be sure to always ask your patient for an authorization number before you make an appointment. The patient may not have one when she first calls, but you can request that she call back with one. Usually, if a patient can supply the physician's name when she calls the MCO to register care, the MCO will assign an authorization number. Frequently, however, the patient calls the MCO for a referral, in which case the names of several physicians may be given, and authorization will not be assigned until the patient informs the MCO of her final selection. It is not uncommon for denial of payment to be attributed to "No Preauthorization" even after the patient has told the practitioner that the treatment was "preauthorized." This occurs because although the MCO gave her the referral, the patient failed to report back with the name of the doctor she selected and so did not get an authorization number.

INTAKE INFORMATION

Poor intake information, such as incomplete or incorrect insurance information, probably accounts for more lost revenue than all other causes combined. When a payer receives a claim without sufficient carrier, plan, or employer information, it is likely to be put aside in a "look-up" pile.

These claims are not considered priority items; "clean" claims are always processed first. Incomplete or incorrect claims will be researched, not by a processor, but by a clerical employee who may, for example, have difficulty connecting the patient to the insured party. These searches are frequently fruitless, and, when that is the case, the claim is typically returned to the physician. When the patient can be correctly identified, the claim is returned to the processing cycle. This additional processing can add days, or even weeks, to the turnaround time.

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The importance of thorough record keeping--starting with making and filing a copy of the patient's insurance card on the first visit and any time there is a change in insurance--cannot be overstated. Key questions to ask on the first visit are:

- Is the patient the insured or a dependent?
- Is there a secondary carrier?
- Who is the secondary carrier? (If there is a secondary carrier, call the carrier to confirm primary versus secondary coverage because there is substantial variance in companies' rules.)
- Whose name is the secondary insurance in? If it's different than the primary policy, be sure to get the insured's name, birthdate, social security number, and the name of the insured's employer.
- Has the care been preauthorized by the secondary carrier? Is it necessary to authorize care through the secondary carrier? Know your plan, and if you do need authorization, be sure to get the name and phone number of the person who grants the authorization.

Get current correct addresses for the insured and the patient, birthdates, and clarification of anything on the insurance card that is unclear. All the intake information is necessary to create a clean, complete claim.

It probably makes sense to ask if there have been any changes in the patient's insurance status at each appointment.

ELIGIBILITY AND BENEFITS

Collecting the patient's coinsurance at the time of service can save a lot of trouble later on. Always call the number on your patient's insurance card to verify eligibility and benefits. In addition to confirming copay and/or coinsurance information, ask for calendar-year maximums, lifetime maximums, plan exclusions, deductibles, out-of-pocket maximum, and timely filing limits. If your patient has a tiered benefit (e.g., visits 1 through 5 at $10 copay and visits 6 through 20 at $25 copay), determine how much of the patient's benefit has been used so far. Remember that the patient's first visit to your office may not be his first visit of the year. It is possible that the MCO authorizes care based solely on medical necessity, irrespective of the patient's eligibility and benefits. An authorization is not a guarantee of coverage.

It is important to remember that most MCO/payer contracts state that when a member becomes ineligible, the payer ceases to be responsible financially or otherwise (even if they told you on the phone that they still insured the patient). What this means is that even though you verify a patient's benefits, the MCO can come back to you in a year with the information that, in fact, that person was ineligible on the date you verified and the insurer wants you to pay them back. Because of this, you always want to make it clear to your patient from the outset that he or his guarantor is responsible for payment when coverage stops.

CERTIFIED CARE

Claims are often denied because the services charged do not precisely match the services that were authorized. Automated claim processing systems, in widespread use today, have decreased the claim turnaround time, but at the cost of a human being able to make a decision based on good judgment. A change in the level of care your patient requires or in the frequency of visits can often result in denied

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charges. This is why it is very important to be in communication with the MCO. Always call the MCO before changing the type of service performed.

In some cases, a phone call to the MCO before the submission of the claim is all that is needed. However, some MCOs may require you to submit an updated treatment plan. Familiarize yourself with the MCO's requirements and know your contract.

SUBMIT A "CLEAN" CLAIM

Using the standard CMS 1500 form, which can be downloaded off the Centers for Medicare and Medicaid (CMS) website (http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf), will go a long way toward preventing missed charges or misread claims. Computer programs are also available to print these automatically from your billing office. If you do not have such a program, you can increase office efficiency by entering all the intake information in the "Patient" and "Insured" information sections on an original form, which can be permanently stored in the patient's file. Use this form to make copies, as needed, so that the additional information relevant to a visit can be entered each time a new claim is submitted. Always make sure the information about the patient, the insured, and the plan is complete and correct on this form because, as we noted above, unidentified claims can take months to process or may just disappear. The physician information must still be completed for each claim submitted, or your superbill can be stapled to the copy of the CMS form. Adherence to the following guidelines will ensure that your claim is processed with maximum efficiency:

- List only one charge on a line; date spanned or combined charges are frequently missed.
- Clearly mark corrected claims as such; automated processing programs may interpret a claim with the same date of service as a duplicate charge.
- Explain codes that may have more than one meaning and indicate length of the visit (e.g., CPT 90841 60 minutes, 75 minutes, etc.).
- Supply the name and address of the facility where the services were rendered in addition to your billing address.

FOLLOW UP

The turnaround time for claims payment varies greatly among plans. If you have been waiting longer than usual for payment, call the MCO to inquire about the status of the claim. Be sure to have all pertinent information available when you call.

Many states have statutes that allow charging interests for late payments by an insurer. Find out about your state laws and charge any interest you are due.

IF YOU DON'T GET PAID

If you notice a pattern of slow payment or nonpayment, you might consider taking these steps:

Develop a Paper Trail.

Try to find someone in the company who can get claims paid. If the person you first make contact with can't help you, you might want to write the medical director's office to report your problem and request immediate resolution. If you fail to get the help you need, write the chief executive officer and

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register an official complaint. Send a copy of your correspondence to any or all on the following list. But first learn who the key players are in your state and whose support you can count on.

- State Insurance Commissioner — Some commissioners are actively involved in taking complaints about fraudulent insurance practices from both physicians and consumers; others may take complaints only from consumers. If the commissioner's office can't help you, you can contact the state's department of health or department of labor.
- Attorney General — If your attorney general is especially active on healthcare issues, write him or her directly.
- APA District Branch/State Association — Your District Branch/State Association (DB/SA) can be an important source of information on MCO activity in your area, and the legislative representative will be able to tell you the status of recent legislation.
- Consumer Advocacy Groups — Patients can register complaints with local chapters of the National Mental Health Association (call (800) 969-NMHA for local phone numbers) and NAMI (call NAMI's Helpline at (800) 950-NAMI for local phone numbers of chapters and affiliates).
- The Media — Many local television stations in large cities have a consumer advocacy segment, and the media have been particularly interested in healthcare issues.
- Congressional Representatives — A sympathetic member of Congress can be very effective in negotiating on your behalf.

If you find that you're still having trouble getting paid, call the APA's Practice Management HelpLine, 800-343-4671, for assistance.

Stay Informed.

Information is power. The APA's "Member2Member" listserv is an excellent way to find out how your colleagues have handled these problems. If you wish to join, send an e-mail to Webmaster@psych.org with the following information: name, member ID number, city, state.

Inform Your Patient.

Keep your patient or a responsible family member informed. Your patient should contact her employer's Human Resources Department. The MCOs are under contract to employers to deliver medical services, and employers review these contracts periodically. If enough employees are dissatisfied, the employers may select another plan or advise the MCO to "fix" the problem.

Go to Small Claims Court.

This is a last resort, but APA members have done this and won.

YOUR MCO CONTRACT/STATE LAWS

- Review your contract. What, if anything, does it say about the MCO's obligations to pay and within what length of time?
- Know your state laws. What do they have to say about prompt payment and the insurers' obligations? How do they define a late claim?

In general, develop effective collection procedures. Some managed care plans routinely check to see if practices ask for copays at the time of service, and if they do not, the MCOs drop them from their

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rosters. Bill and follow-up regularly on outstanding claims. Do not let accounts age without knowing their status with the MCO. Banks consider outstanding debts "bad" and uncollectable after three months. Be aware that your contract may set time limits on billing.

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