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GETTING PAID

A common complaint from psychiatrists is that insurers, or managed care companies (MCOs), are slow to pay their claims or don't pay them at all. The following suggestions should 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 the number. 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. Once 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.

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 insurer?
- Who is the secondary insurer? (If there is a secondary insurer, call them 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 insurer? Is it necessary to authorize care through the secondary insurer? 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.

To be completely safe, 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 maximums, 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 claims processing systems 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 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, a sample of 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 90899 – specify what the unlisted psychiatric service was and the length of time spent).
- When appropriate, supply the name and address of the facility where the services were rendered in addition to your billing address.

FOLLOW UP

The turn-around 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 interest for late payments (as defined by state law) 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 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 —** Your District Branch (DB) can be an important source of information about the experiences other psychiatrists have been having in your locale, and the legislative representative should 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, contact the APA's Practice Management HelpLine, hsf@psych.org or 800-343-4671, for assistance.

Inform Your Patient

Keep your patient or a responsible family member informed. Your patient should be advised to 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 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.