OUTPATIENT FEE ASSESSMENT AND COLLECTIONS

OPERATIONAL PROCEDURE

March, 1988 (rv 4/93, rv 9/94, r 6/96, rv 2/97, 4/99, 9/02, r 9/05, rv 11/07) (rv 4/10, 11/10, 12/10, r 7/14) **Policy Ref**: 110-06

Reviewed/**Revised**: April, 2017 **Procedure**: 110-04

A. PURPOSE:

Fees for services are an essential part of financing the Center operations. Payment for service is both normal and enhances the therapeutic value of the service. Therefore, it is the function of this procedure to establish a mechanism wherein individuals pay some part of the cost of service received, to the extent of the individual's ability to pay.

B. PROCEDURE:

Initial Contact

I. Staff scheduling an intake appointment for a potential individual, either in person or over the telephone, shall inform the potential individual of the Center's fee policy. This information will include the Center's policy regarding fees and the opportunity to set fees for services. The potential individual shall be asked to bring verification of income and any information regarding any third party coverage for payment of fees (including policy handbook and insurance card) to his/her first appointment.

II. Minor individuals (under 18 years of age) or a person for whom a legal guardian has been appointed must be accompanied by a parent or guardian to execute forms normally required to be signed by an individual, except:

a) Married persons are not considered minors regardless of age.

b) The institutional representative will act as the guardian of person and estate for a minor in a public or private institution. Parents presenting a minor child are responsible for all charges based on the parent's financial resources.

III. Individuals with a previous balance may be refused services. However, services will not be denied before a clinical decision is made as to whether to deny services. The decision must be based upon the individual's current mental condition and the need for treatment. No emergency services will be denied because of a failure to pay the assigned fees.

IV. All persons requesting services, regardless of referral sources, will be required to pay for services based on the Center's sliding fee schedule and other contractual allowances. The fee schedule can be reduced based upon extenuating circumstances as approved by a Program Director or a Vice President.

Admission, Fee Assessment and Adjustments

I. Individual’s demographic, case history and financial information shall be obtained at the intake/screening during the individual's first scheduled Center appointment.

Assistance from collaterals may be required to complete this information for persons with severe mental or emotional problems.

II. Patient Guarantor and Agreement for Treatment shall be completed for each individual during the initial session. Center policy is to charge each individual for services based on his/her ability to pay.

a) Charges for services are set during the initial interview if this has not already been done via telephone contact. Each individual is established a charge for services based on his/her ability to pay. The clerical staff will set the fee using the Center's Sliding Fee Scale. The fee is based on gross income and the number of dependents in the household.

b) Persons residing in an adjoining county outside the Center's catchment area that do not have a third party payment source shall be referred to the behavioral health center in his/her county for services. However, no person shall be denied access to emergency services based on the ability to pay or place of residence.

c) Persons shall be informed that services are on a cash basis and payment is expected at the time services are rendered.

d) Those individuals refusing to participate in the fee assessment process or electing to not assign insurance benefits will be charged full fee for services. Such refusal shall be explained to the individual and be documented by the clerical staff in the Center’s Billing System (TIER).

e) A ten dollar ($10.00) charge shall be assessed for failed appointments and for individual, family or marital sessions canceled or rescheduled without at least prior day notice to the attending clinician or a member of the clinic office management staff. Any such charge shall be issued directly to the individual of record for payment, and continuation of outpatient services may depend on the individual's payment of his assessed fee.

f) Assessments become effective on the date of intake and are evaluated every three (3) months thereafter.

1. The clerical staff is to reassess at each three (3) month interval and evaluate the fee contract and prepare a reassessment when due. If the current assessment is to be continued as written, the clerical staff may note “No Change” in the Center’s Billing System (TIER).

2. The clerical staff may reassess fees whenever deemed appropriate by changes in the individual's financial status, or when the individual is to receive services not included in the initial assessment.

Third Party Reimbursements

I. Private Insurance/PPO/HMO Contracts/Champus, et al

a) When an individual with third party coverage first contacts the Center, the procedure listed below shall be followed.

1. The clerical staff shall obtain insurance information and have the individual sign the authorization on the Patient Guarantor form. If special forms are needed for filing insurance, the clerical staff must obtain them from the individual.

2. The individual's policy handbook and insurance card are to be copied and the copies are to be forwarded to the Insurance Department.

3. The clerical staff shall call for verification and authorization of services. They shall notify the provider of services as to how many services are authorized prior to the patient receiving services. A copy of the completed authorization/verification form shall be filed in the patient's chart and the original filed in the Insurance Department. In the event a prospective individual requires immediate treatment, every attempt will be made to obtain, authorize and verify insurance information and coverage while the individual is on site.

4. If the individual refuses to sign an Assignment of Benefits form, or if the insurance benefits will be paid to the individual only, the fee shall be assessed at 100% for services covered by the individual's assessment and treatment.

5. Every attempt will be made to allow the individual full benefit of his insurance coverage by assuring that the services he/she receives are delivered by the clinical category specified under his/her insurance policy. The Center reserves the right to recommend the service indicated to be in the best interest of the individual and clinician.

6. The steps below must be followed in processing the insurance claims for individuals:

a. Psychiatrist electronically signs: Initial Evaluation, Face Sheet, Treatment Plan (1 x only) and Psychiatric Evaluation.

b. Send Insurance Department a READABLE copy of: Face Sheet, front and back of insurance card (with phone number for verification), Patient Guarantor Agreement, and income.

c. Document on Feedback when insurance confirmation is received. Indicate "FULL FEE INS" on Face Sheet in scale status box. Highlight chart label yellow.

d. Collect co-payment at the time of service. ANY OTHER ARRANGEMENT MUST BE APPROVED BY BUSINESS OFFICE.

e. Diagnosis and scaled fee should be documented.

f. Notify Insurance Department of any changes in individual's status such as change in income, insurance or diagnosis.

g. Unemployed, disabled or retired individuals' Face Sheets should indicate an "unemployed teacher" or "disabled steel worker" or "retired postal worker."

h. When processing insurance for children whose parents both have coverage, the BIRTHDAY RULE must be applied. The parent whose birthday comes first would have primary coverage (i.e.: father's birthday is 5/01, mother's birthday is 5/27; the father's insurance would be primary.

i. Individuals who have an insurance which we have a PPO or HMO contract with will only be billed for the amount agreed upon in the contract.

j. The Insurance Department will file primary and secondary insurance. The individual, however, will be responsible for his/her bill.

II. Medicare and Medicaid

a) Individuals who present with Medicare or Medicaid will have their coverage verified prior to having services rendered. Questionnaire must be completed on all Medicare individuals. If it is found there is another insurance that is primary, that insurance will be filed prior to Medicare or Medicaid.

b) Medicare and Medicaid programs cover only certain services. For those services not covered by the programs, the individual will be given an Advanced Beneficiary Notice advising them of the non-covered services before the service can be provided.

1) LifeStream Behavioral Center will bill Medicare and/or Medicaid for all medically necessary services up to maximum benefits.

NOTE: LifeStream will collect all co-pays and deductibles from Medicare and Medicaid individuals as required.

2) During the scheduled reassessments, the clerical staff shall see each individual with private insurance, CHAMPUS, Medicare and/or Medicaid to update information on third party coverage.

3) Outpatient Facilities.

a. It shall be the responsibility of each clerical staff to obtain insurance information. This includes insurance forms, copies of Medicare and/or Medicaid cards, etc.

b. Each clerical staff shall be responsible for obtaining third party coverage information reassessment.

c. Persons with the ability to pay the agreed charges for service but refusing to do so may be denied further services until an agreement on a payment schedule has been set. The individual's mental condition and need for services must be considered when making a determination to deny services. Termination of further services shall be documented on the service ticket in the "Next Appointment" section and initialed by the service provider. The service provider shall document such actions in the individual's clinical record and report this determination to the program manager or supervisor.

PROCEDURE APPROVED:

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QI/RM Director

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Date