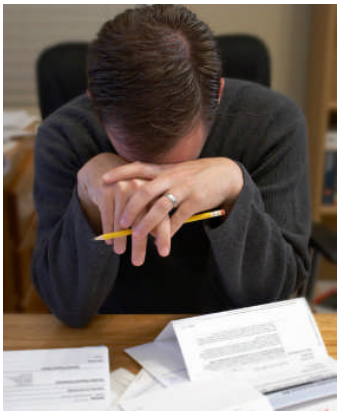
RMD Bulletin

Knowledge is power…

CLIENTS WITH OTHER HEALTH COVERAGE: A REMINDER ABOUT INSURANCE BILLING



WHAT YOU NEED TO KNOW!

In our review of Medi-Cal denials, Revenue Management Division (RMD) noted that providers have been receiving a disproportionate number of denials for Other Health Coverage (OHC). From this review of the data, it appeared that providers were not billing OHC prior to billing Medi-Cal for services to clients with private insurance in addition to Medi-Cal coverage when it was appropriate to do so. The State of California requires all Medi-Cal providers to bill private insurance companies for services rendered to Medi-Cal beneficiaries who also have private insurance. Welfare and Institutions Code Section 5872 states that participating counties shall collect reimbursement for services from fees paid by private or public third-party payers. The State has allowed only two exceptions to this requirement for specialty mental health providers: Targeted Case Management (procedure code T1017) and Therapeutic Behavioral Services (TBS) (procedure code H2019). Further investigation of OHC billing practices revealed that many providers also were not billing the client's insurance even when it was the only coverage identified for the client.

WHAT DOES THIS MEAN TO YOU?

Based on the State requirement, every provider is required to identify all third party billing resources for each client and bill those resources accordingly. Beginning when the State updated and upgraded its system with the implementation of Short-Doyle/Medi-Cal Phase II, our claims give Medi-Cal information that demonstrates when we have billed other third party payers and have received an approval or denial when a client has other coverage in addition to Medi-Cal. Every claim must include the specific HIPAA compliant adjudication response from the other payer on the Medi-Cal portion of the claim: the subscriber identification, the amount paid by the other payer, the adjudication date, and the specific adjustment reason codes explaining why the claim was not paid in full by the primary payer. **This means that you must bill the client's insurance *for every service* as appropriate; denial letters from the insurance company are not acceptable.**

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DOES NOT APPLY TO FEE-FOR-SERVICE PROVIDERS

RevenueManagement@dmh.lacounty.gov

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WHAT SHOULD YOU DO?

Short-Doyle providers must bill all applicable payers for all eligible services to clients. If the client has other health coverage, then you must bill the private insurance for every service rendered to that client. The State only allows providers to submit Targeted Case Management and TBS claims directly to Medi-Cal without being adjudicated by private insurance first. If another service was rendered or if the client does not have Medi-Cal, then providers must attempt to obtain reimbursement from the insurance company.

Follow these basic steps to ensure that you optimize reimbursement from the insurance company.

- Financial screening: Make sure to obtain complete and accurate billing information for each client. Don't forget to get the subscriber's information as well as the group number and member number, which are needed for billing.
- Medi-Cal eligibility check: Look for other insurance information in your eligibility response. Below is a sample printout. The OHC portion of the response is in bold.

LAST NAME: ROBERTS. EVC #: 1111AAAAAA. CNTY CODE: 19. PRMY AID CODE: 60. MEDI-CAL ELIGIBLE W/NO SOC/SPEND DOWN. **OTHER HEALTH INSURANCE COV UNDER CODE B. CARRIER NAME: ACME HEALTHCARE. COV: IOMPVL.**

- Billing: Call for authorization and instructions on how the insurance wants you to bill. Regardless of whether the service is authorized, bill the insurance company for any service rendered. **All charges are to be billed within 30 days of service**. If the client does not want their insurance billed, or refuses to release information, they must accept liability for, and pay full cost of care. (If the client has Medi-Cal, the services should be billed to Medi-Cal without insurance adjudication information. These services will be denied and are not billable to the client.)

In the event that you have submitted a claim to the client's other health coverage and you have not received an approval or denial from that other payer within ninety (90) days, then the claim can be submitted to Medi-Cal by entering $0.00 as the Amount Paid and use the Adjustment Group OA and the adjustment reason code A7 for the entire claim amount on the Other Payer screen. This adjustment code is not to be used unless you have contacted the payer on a regular basis to follow up on the status of your claim and that these payer contacts have been documented in the client's financial folder. You have to follow up with the insurance company before you can use this code.

We're here to help you…

If you have any questions or require further information, please contact RMD at (213) 480-3444 or RevenueManagement@dmh.lacounty.gov.