July 25, 2001

TO: Fee Assessors Meeting Attendees

FROM: Carol Erickson- Anoka County, Placement Support Specialist

RE: Anoka County's Procedure for Insurance Reimbursement

I hope the following information is helpful. If you have any questions, feel free to give me a call at, 763-422-7084. I will be more than happy to help. I am available T-F 7am-3:30pm.

We first encourage the Social Workers and Probation officers to try and set up services with Vendors that the clients insurance will cover. Clients are asked to find out if their insurance will cover the service and if so request pre-authorization. I have enclosed copies of the letters that are sent to the Social Workers, Probation Officers and Clients.

Also, provided to the workers, are the phone numbers that the clients should call when requesting pre-authorization. It includes the information that might be requested from the client, in order for the insurance company to determine whether or not the service will be authorized. It is the clients responsibility to contact their insurance company not the workers. The worker assists the client in obtaining the information that will be asked.

It is best to advise parents that when they call their insurance providers that they not mention the county, Probation officer and/or Social Workers involvement. We have had instances in which the insurance provider will deny claims because they know that the county is actually paying for service or the service is court ordered.

The types of service that we file claims for are:

-Residential Treatment
-Evaluation Placement
-Outpatient/Counseling services

Note: We do have a person that files claims for Detox services.
Jackie Schuetzler 763-422-7190.

Before filing claims we need a Health Insurance Release form (copy enclosed) signed by the parents, diagnostic codes (request from Probation Officers and Social Workers) and record that county paid for service. The corrections department has an additional release form. When I request diagnostic codes and/or copies of psych. evals or discharge summaries, the Probation Officers obtains a release that is signed by the parents and child. The release specifically states what information they are releasing to me.

Parents have 3 possible ways that they might receive the insurance release form.

-Social Workers/Probation Officers
-Collections Department
-or I request the form from the client

There are two signature lines on the release form. One line is to authorization release of information to the Insurance company. The other is to authorize release of any payments to the county. Sometimes in error the insurance companies reimburse payments to the Vendors or Clients. I would then contact the Vendor and request the funds be returned to Anoka County. If a payment were made to the client, I notify our collections department and they collect the money from the client.

All claims are filed on a UB-92 form or if requested by the insurance provider, a HCFA1500(copies enclosed). You can order the forms from the American Medical Association. You can not hand write a UB-92 form. We have a program for completing the UB-92 on the computer. The program is called Delrina. If you want information about this program, you can call my supervisor Kim Verbugge at, 763-422-7073.

Based on a training seminar that I attended through Blue Cross/Blue Shield and through trial and error, this is how a UB-92 form is completed (example of residential treatment and counseling enclosed):

Box #
1-Vendor name and Address
2-Blank
3-Client # assigned by County
4-Code (Codes are found in the "Uniform billing Manual" a must to have. You can order one by contacting State Uniform Billing Committee 6215 W ST.Joseph Hwy, Lansing, MI 48917 Phone# 517-323-3443)
5-Vendor's tax id #. When there isn't one, we use our county tax id #
6-date of service that the claim is covering.
7-11-Blank
12-name of person who rec'd service. No middle names. Only middle Initial. So far it hasn't mattered whether the first name is first or the last name
13-Address (only BC/BS requires)
14-B-date of person who rec'd service
15-Male or Female M or F

16-Martial Status M-Married S-Single
17-Date service began
18-Blank

19-20- Code from Uniform Billing Manual
21-Blank
22-Code from Uniform Billing Manual
23-37-Blank
38-County name and address
39-41)Blank
42-code from Uniform Billing Manual. We use 124 for Residential treatment and Eval placements .9-- outpatient and counseling you will need to check the manual for the two digits after the 9
43-Describe Service example: Residential Treatment, Diagnostic assessment, Group Therapy, Family Therapy. The bills you receive from the Vendors for counseling services should have a description of the service and CPT codes (copy enclosed) I put this info in this box example: 90806-Individual Therapy 90847-Family Therapy
44-rate of service
45-I only fill in for counseling services
46-# of days or hours of service
47-rate X # of units of service
48-49-Blank
50-Insurance Provider Line A- Primary Line B-Secondary
51-Each Insurance provider assigns each Vendor a provider number. This box is blank on most of my claims. If necessary, you can contact the Vendor and ask them for the number.
52-Asking whether or not you have a signed release for information Y-yes N-no
53-Asking whether or not you have a signed release to accept payment Y-yes N-no
54- If you are filing a claim for secondary insurance and the primary insurance made a payment. That amount goes in this box
55-Total amount of claim
56-57-Blank
58-Policy holder name
59-Some insurance providers assign two digit numbers to each member on the policy. I only fill it in when it is requested so far BC/BS has requested it but inconsistently.
60-Policy #
61-Blank
62-Group #
63-64-Blank
65-Employer name
66-Blank
67-75-Diagnostic Codes. You probably will only have 1-4 codes
76-83-Blank
84-Put County's tax id # and any Axis II-V codes
85-Your signature
86-Date you completed form

-Allow 3 months for the insurance providers to process claims. If no response after 3 months send a letter requesting status of claim (copy enclosed). Wait 3 more months. If still no response, then you can call or send 2nd request. Try and do most correspondence in writing.

-Any phone conversations with insurance representatives **should be documented in detail, dated and obtain name of person** you spoke with. Representatives within the same company will give you conflicting information. When I think I have understood what they have just told me, I repeat it to them to make sure that I am on the same line as they are. This is very important!!!!!!!!!!!!

-Everything you send to insurance, make a copy. I keep detailed logs of all activities. Anything you receive from insurance companies keep. This is very important!!!!!!!!!!!!!!!!!!!!!!!!!!!!

-Most insurance providers allow 1 yr from date of service to file a claim. Don't delay in filing claims. You can file a claim that is over a year old but many times they will say that the time frame for filing has expired. It never hurts to try. When clients request that I file a claim that is over a year old, I tell them that they need to contact their insurance provider to verify whether or not they will accept it.

-It is not unusual for the insurance companies to claim that they never rec'd your claim. You may have to resubmit the claim. When I have correspondence from insurance providers that prove that they did receive my claim, then I don't resubmit the claim. I make copies of original claim, the correspondence from insurance provider and a letter requesting status of claim.

-If Medica sends a remittance statement and it has code 457. It means that they want medical information. They want proof that service is medically necessary. I send copies of psych. evals, diagnostic assessments, discharge summaries, description of programs. This is sent with a copy of the remittance. Keep original.

-BC/BS very picky about forms. All writing must be in boxes, not on the lines.

-If insurance Denys claim because of lack of authorization. I send a letter to parents stating that claim was denied, the reason for denial and that they can contact there insurance and request retro-authorization of service.

-When filing a claim, there is no need to send any type of letter with the claim. Just send the claim.

-If insurance Denys because not covered service, then send a letter to the clients stating that they can appeal decision. I have had two clients that were real assertive with their insurance provider and were able to have service paid in full or partial. One child was out right denied. The mother called and was able to have a certain number of days paid. She called again and the whole service was paid. Another child was in residential treatment and the mother was able to have the counseling portion of the service covered by the insurance.

-Even if service is denied keep filing claims. Each claim is reviewed and processed by a different person. One person may pay for one month of a child's stay and another may deny the next month. If this happens, then start appealing and challenge the denial.

-I only return money when I receive a written request or double payments for same time periods. Note: even if it is a written request you may want to challenge or appeal before sending the money back.

-When a client has two or more insurance providers and you don't know which is primary or secondary, file a claim with both insurance providers.

-When it states one is primary and one is secondary still file a claim with both. Once the claim is processed by the primary insurance provider and you receive the EOB/Remittance, send a copy of the remittance, a new claim form(with adjusted amt, if necessary) and a copy of original claim to the secondary insurance provider. I have been told that you can wait for the EOB/remittance before filing a claim w/secondary and I have been told that you have to file the claim before receiving the EOB/Remittance. The safest, is to file both right away, otherwise it could be denied for lack of timely filing.

-Even if a client calls their insurance provider and they are told that the service is not covered. I still file claims. Sometimes insurance still pays for the service even though they told the client that it is not a covered service or not authorized.