DISTRICT 19 COMMUNITY SERVICES BOARD

REIMBURSEMENT POLICIES AND PROCEDURES

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RB 001 INTRODUCTION

District 19 CSB (CSB) is managed by the Executive Director who is responsible for the administration and clinical service delivery.

Reimbursement is a part of the administrative function. District 19 CSB will have on staff a Reimbursement Supervisor whose main responsibility is to maximize consumer and third party reimbursement, and see that the Code of Virginia is followed as it relates to CSB reimbursement.

RB 002 RESPONSIBILITY AND AUTHORITY FOR REIMBURSEMENT

A. Code of Virginia, § 37.1-197(7) - CSB; powers and duties.

A CSB shall:

"Prescribe a reasonable schedule of fees for services provided by personnel or facilities under the jurisdiction or supervision of the board and establish procedures for the collection of the same. All fees collected shall be included in the performance contract submitted to the local governing body or bodies pursuant to subdivision 2 hereof and § 37.1-198 and shall be used only for community mental health, mental retardation and substance abuse purposes. Every operating board and local government department with a policy-advisory board shall institute a reimbursement system to maximize the collection of fees from persons receiving services under their jurisdiction or supervision consistent with the provisions of § 37.1-202.1 and from responsible third-party payors. Operating boards and local government departments with policy-advisory boards shall not attempt to bill or collect fees for time spent participating in involuntary commitment hearings pursuant to § 37.1-67.3".

B. § 37.1-202.1 - Liability for expenses of services.

"The income and estate of a consumer shall be liable for the expenses of services under the jurisdiction or supervision of any operating CSB, administrative policy board, or local government department with a policy-advisory board that are utilized by the consumer. Any person or persons responsible for holding, managing or controlling the income and estate of the consumer shall apply such income and estate toward the expenses of the services utilized by the consumer.

Any person or persons responsible for the support of a consumer pursuant to § 20-61 or a common law duty to support shall be liable for the expenses of services under the jurisdiction or supervision of any operating CSB, administrative policy board, or local government department with a policy-advisory board that are utilized by the consumer unless the consumer, regardless of age, qualifies for and is receiving aid under a federal or state program of assistance to the blind or disabled. Any such person or persons responsible for support of a consumer pursuant to § 20-61 or a common-law duty to support shall no longer be financially liable, however, when a cumulative total of 1,826 days of (i) care and treatment or training for the consumer in a state mental health facility or training center; or (ii) the utilization by the consumer of services under the jurisdiction or supervision of any operating CSB, administrative policy

board or local government department with a policy-advisory board; or (iii) a combination of (i) and (ii) has passed, and payment for or a written agreement to pay the assessment for 1,826 days of care and services has been made. Not less than three hours of service per day shall be required to include one day in the cumulative total of 1,826 days of utilization of services under the jurisdiction or supervision of any operating CSB, administrative policy board, or local government department with a policy-advisory board. In order to claim this exemption, the person or persons legally liable for the consumer shall produce evidence sufficient to prove eligibility therefore."

(1982, c. 50; 1984, c. 431; 1998, c. 680.)

RB 003 INTERNAL CONTROLS

Proper control and segregation of duties between the functions relating to billing and collections ensures the integrity of accounting and reimbursement data.

Segregation of Duties

There shall be adequate segregation of duties between the billing and collection functions as outlined below:

Accounting staff or clinic support staff will collect money and issue pre-numbered receipts. Accounting staff will track and issue pre-numbered receipt books. Clinic support staff should maintain accountability of all pre-numbered receipts and, once all receipts are issued, return the receipt book to the Accounting Manager.

Central Reimbursement staff will submit monthly billings and post payments to consumer accounts. The Accountant not directly involved in the cash receipts or billing functions will prepare monthly bank reconciliations by the end of the following month.

Reconciliations

The Reimbursement Supervisor not directly responsible for collecting cash, making deposits, or posting payments to consumer accounts will reconcile monthly bank deposits with consumer fee receipts posted to consumer accounts by the end of the following month.

The Reimbursement Supervisor will also reconcile monthly the Medicaid fees collected with bank deposits and the Medicaid Remittances distributed by the Department of Medical Assistance Services by the end of the following month.

RB 004 CONSUMER FEES AND REIMBURSEMENT

A. Statement of Policy

It is the policy of District 19 CSB that consumer fees and reimbursement will be based on the following Board policies:

1. The CSB subscribes to administrative and fiscal practices that do not present a barrier to the availability and accessibility of services.

2. The CSB shall prescribe a schedule of fees for services provided by personnel or facilities under the jurisdiction or supervision of the Board and establish procedures for the collection of the same. In determining prescribed fees the following will be considered: 1) cost of services; 2) estimated costs associated with billings; and 3) compliance with contracts established with third party payers.

3. The CSB will charge all consumers receiving the same service the same fee for these services.

4. The CSB will not deny services based solely on the consumer's ability to pay.

B. Schedule of Fees

1. District 19 CSB will charge for services based on the Board approved Schedule of Fees included with these policies (See Appendix).

2. Specific fees may be agreed to with public and private entities at amounts different from the Board approved fee schedule provided the agreements do not violate any existing federal/state regulations governing the establishment of such fees. These agreements must be reviewed and signed by the Director of Finance and Administration and the Executive Director, and Central Reimbursement will ensure that billings are submitted in accordance with the agreements.

3. Changes in fees shall become effective no sooner than 30 days after the date of approval by the Board of Directors. Consumers will be notified prior to the effective date of the revised fees through postings at the clinic/program site and through notices included on the monthly billing statements. Services received after the date of the change will be charged at the new rate.

C. Minimum Fees

While circumstances of hardship may be considered on an exception basis, District 19 CSB will charge a minimum fee equal to 1% of the Board approved rate per visit by

allowing no more than a 99% discount based on the Fee Subsidy Scale (See Appendix). However, consumers with a total family income less than $14,356 per year will be charged no minimum fee, eliminating the fee appeal process for these consumers. This amount will be compared to the current Health and Human Services Poverty Guidelines to determine if revisions are needed.

D. Charges for Other Services

1. **Court Appearances by Staff/Clinician** – The fee for a court appearance will be based on the fee established in the Schedule of Fees (See Appendix). The full fee will be required from the party requesting the appearance. When an attorney in a civil matter subpoenas staff/clinicians, the attorney issuing the subpoena will be billed. When staff/clinicians are subpoenaed in a criminal matter, a bill will be sent to the defense attorney when his office issues the subpoena. **If a subpoena is issued on behalf of the court (state or federal), no bill will be generated.** Billable time for court testimony includes, but is not limited to, preparation time, copying fees, travel time and time spent at the court prior to or following testimony as may be necessary.

2. **Consumers Referred by Other Agencies** – When other agencies request services on behalf of a consumer, services will be billed at the rate established in the Schedule of Fees or by separate agreement.

   (a) If the referring agency will be responsible, an authorization for payment must be received from the referring agency prior to providing services, and included with the Financial Assessment (See Appendix) which lists the referring agency as responsible party.

3. **Staff of other CSBs** – Staff that work for another CSB and need to be seen elsewhere because of confidential concerns may be seen by District 19 CSB regardless of whether they live within the District 19 catchment area. However, if the individual lives outside of the CSB catchment area, they must provide proof of employment with another CSB in order to be eligible for the fee subsidy and fee appeal process as outlined in the Reimbursement Matrix (See Appendix). If they live within our catchment, they will automatically be eligible for the fee subsidy and fee appeal process.

4. **Consumers from other CSB Catchment Areas** – Although consumers are allowed to seek services outside of their catchment area, consumers from other CSB catchment areas should only be served if there is capacity in the program. Billing will be submitted to third party insurances; however, the consumer will

be responsible for the full fee charged for services if they do not have insurance or if they have insurance with which District 19 CSB does not participate.

E. Financial Assessment

1. A financial assessment should be conducted at the consumer's initial visit to District 19 CSB.

2. A financial assessment should be completed at the initial intake process, and annually thereafter, to determine the consumers' liability for services. At the time a financial assessment is completed, the consumer should be made aware of District 19 CSB billing policies.

3. The Financial Assessment includes information used for billing purposes. The consumer/responsible party is required to sign the agreement accepting liability for any charges incurred; however, signatures are not required when the assessment is being updated for changes in Medicaid coverage or address information. A copy of the assessment should be provided to the consumer/responsible party.

4. Financial information must be reviewed with the consumer each time services are rendered to verify assessment information is still accurate. A statement must be signed by the responsibility party verifying the information provided is accurate at that time.

5. Although the clinic staff plays an important role in gathering financial information from the consumer, it is ultimately the responsibility of the consumer to notify District 19 CSB of any changes in financial status, insurance eligibility, or billing address. Failure to provide updated information does not relieve the consumer of any liability for charges incurred.

6. Consumers with Commercial Insurance with which District 19 does not participate will be billed accordingly:

    a) Case Management, Crisis, Other SPO, and Medical Services will be billed at consumer's discount
    b) SA and MH Outpatient services will be billed to consumer at full fee.

7. Consumers with Commercial Insurance with which D19 accepts will have the option to receive services at a clinic with a credentialed provider or can elect to receive services at a clinic with a non-credentialed provider and be billed full fee. The exception to this rule is Crisis services. Crisis services rendered by a non-

credentialed provider will be written off.

8. Non-covered services by a payer that D19 accepts will be billed at the consumer's discount.

F. Fee Subsidy Scale

1. District 19 CSB subsidizes fees based on a consumer's or responsible party's ability to pay, as documented in the Fee Subsidy Scale. If the subsidized fee causes severe financial hardship, the consumer may then appeal the fee.

2. The ability to pay is based on total family gross income and the number of dependents in the family unit. Total family gross income includes all income received by the family unit, prior to deductions for taxes, insurances, etc. It includes, but is not limited to, salaries, Supplemental Security Income, Social Security Income (SSI), Social Security Disability Income (SSDI), ADC, pension and retirement income, workers' compensation benefits, unemployment benefits, child support, alimony, and interest and dividends from investments. The consumer must provide documentation of income, such as check stubs or bank statements, and copies should be maintained at the point of service, scanned in the electronic health record (EHR) and maintained in the consumer record. Dependents include all individuals who are members of the family unit and who depend solely on the total family unit gross income. The total number of dependents includes both those listed as having income and those with no income.

3. The Sliding scale does not apply in the following circumstances:

   a) If the consumer fails to provide income documentation at time of financial assessment, charges will be billed at full fee until such documentation is provided.

   b) If a consumer is covered under an insurance plan which District 19 CSB participates with, and the consumer elects not to use this insurance for covered services, the fee for these services will not be eligible for the fee subsidy or fee appeal process.

      Consumers who are "potentially eligible" for Medicaid shall be monitored by clinical staff to insure that consumer applies for Medicaid.

      Clinic staff responsible for verifying eligibility will be responsible for completing adjustments and updating the financial assessment.

3. Co-payments and deductibles charged by the consumer's insurance carrier are not discounted on a regular basis. Insurance regulations require that policyholders be assessed the deductible or co-payment that applies to the coverage that is in force for that plan. Any reduction or waiver on a regular basis of deductibles or co-payments is a violation of such regulations.

4. The Fee Subsidy Scale will be compared to the Health and Human Services Poverty Guidelines to determine if revisions are needed.

G. Fee Appeal Process

1. The first step in addressing a consumer's inability to pay assessed fees will be to offer an extended payment plan. (See section on Collections.) For consumers for whom this arrangement would cause financial hardship due to extenuating circumstances, such as high medical costs, the appeal process will be available. A fee appeal is a more in-depth review of the financial responsibility form, and should only be used on an exception basis.

2. An appeal may also be submitted if the consumer has extenuating clinical reasons for appealing the fee. This reason must be documented by clinical staff, and should only be requested to reduce the risk of causing detriment to the consumer.

3. While the fee subsidy scale for District 19 CSB is based on total family gross income, the fee appeal takes living expenses into consideration. The initiator will recommend an appropriate discount based upon information obtained during the fee appeal process.

4. The fee appeal will be valid for no more than one year.

5. Approvals should be obtained from the Clinic/Program Manager and Division Director prior to submitting the appeal to Central Reimbursement for review by the Reimbursement Supervisor and Director of Finance. Any recommended discount will be effective with the approval of the Disability Director. Central Reimbursement will review the appeal and notify the consumer/responsible party and appropriate clinic or division of approval within 30 days of receipt and process the necessary adjustments in the automated billing system.

7. If the fee is disputed after the fee appeal process, the consumer and/or responsible party may appeal to the Director of Finance, and then to the Executive Director.

8. The following expenses are allowed in computing total family net income, with

maximum limits as indicated:

Payroll income tax deductions	Actual monthly expense
Payroll health insurance deductions	Actual monthly expense
Housing (main residence)	Actual monthly expense
Utilities (gas, water, electric, trash)	Actual monthly expense
Telephone (basic service only) or cell phone if no land line	Actual monthly expense
Medical bills (doctor, meds, insurance)	Actual monthly expense
Credit Cards	Limited to minimum required payments
Transportation (Includes auto loans, insurance, gasoline, transportation services and repairs)	Maximum $300/month
Food and clothing (Must include any assistance in total gross income)	Allowance based on family size 1 - $300/mo 2 - 450/mo 3 - 525/mo 4 - 600/mo 5 or more 750/mo
Other expenses may include:	
Education Loans	Actual monthly expense
Child Support	Actual monthly expense
Tax Liens	Actual monthly expense
Alimony	Actual monthly expense
Child Care	Actual monthly expense

Expenses for cable television or cellular telephone services (when land line is also utilized) will not be allowed.
Actual expenses for food and clothing may be used if documentation is provided and actual expenses are more than the allowance shown above.

If a person receives assistance for any item claimed as an expense, the amount received must be included in gross monthly income. (Example - consumer receives food stamps and uses above allowance for food and clothing on the fee appeal).

RB 005 BILLING

A. Timeliness of billing

1. Fees are considered due and payable at the time service is rendered. Every effort should be made to collect from consumers at this time any part of the fee for which they will be responsible (i.e., fee based on fee subsidy scale or co-payment if a third party payer exists).

2. To maximize the collection process, billing should be submitted to the appropriate payer in a timely manner, and billing will be generated monthly.

B. Credentialed Providers

If a consumer is covered by a third party insurance carrier with which District 19 CSB participates, every attempt should be made to have providers credentialed with that carrier provide service for that consumer in order to prevent lost billing.

If there is no credentialed provider available, the consumer will have the option to receive services at another clinic where there is a credentialed provider or be billed full fee.

The exception to this rule is Crisis services. Crisis services provided by a non-credentialed provider will be written off.

C. Eligibility Verification

1. To facilitate accurate billing, clinic/program staff is responsible for verifying the third party coverage of consumers monthly and indicating in the EHR that verification was completed. The clinic/program site will enter changes in EHR. Any changes in coverage should be communicated to Central Reimbursement with an updated Financial Assessment. Typical changes would be the addition of Medicaid coverage or lapsing of payors. These do not require consumer signature.

D. Account Adjustments

An Adjustment Request should be completed and approved by the clinic/program manager to adjust charges recorded in a consumer's account. Proper documentation supporting the change should be attached to the adjustment request and forwarded to Central Reimbursement. Central Reimbursement will process adjustments within 1 month of receipt.

RB 006 COLLECTIONS AND DENIAL FOLLOW-UP

A. General Policy

1. Payment for services is expected from consumers at the time of service for any part of the fee for which they will be responsible (i.e., fee based on fee subsidy scale or co-payment if a third party payer exists).

2. The clinic/program staff are expected to assist in the collection process by emphasizing that payment is part of the consumer's responsibility. The clinician should take a small part of the session to discuss past due balances, circumstances that may be affecting payment, and positive or negative changes in the consumer's financial status requiring an updated financial contract.

B. Denial Follow-up – Third Party Payers

1. Denials will be worked based on Payer Path abilities.

2. Services provided without required prior authorizations are not billable and should be written off. The consumer is not responsible for these charges. However, if the third party payer deems the service non-covered, the consumer will be responsible for the charge at the appropriate discount determined in the fee subsidy process.

C. Collections Process – Self Pay

1. Copays for outpatient clinic services should be collected prior to services being rendered. For Self Pay consumers, the full amount based on ability to pay should be collected prior to services being rendered.

2. Monthly billings to consumers will include a statement that payment is expected within 30 days from date of statement.

3. When accounts reach 120 days past due from date of service, the clinician shall meet with consumer about past due balances, instructing consumer that if payment in full is not received within 60 days, services can be terminated. This meeting shall be documented in the consumer's record.

D. Discontinuing Services Due to Non-Payment

1. Consumers who allow their accounts to age 180 days shall have their service discontinued unless, in the opinion of the clinician, discontinuing services would result in substantial likelihood that the consumer will in the near future cause serious harm to himself or others. At least one month prior to termination, the clinician shall provide the Division Director a written recommendation on whether services should be discontinued, in accordance with this policy. Within 10 business days from receipt of clinician's recommendation, the Division Director and Medical Director shall review and notify the consumer in writing if services will be discontinued. The consumer shall be notified that they may appeal this decision if they believe that the fee charged was not calculated correctly based on their ability to pay.

2. Consumers who have previously discontinued services and wish to return to District 19 CSB must pay any prior outstanding balance in advance.

E. Write-Off of Uncollectible Accounts

1. Consumer receivables determined to be uncollectible will be written off from the accounts receivable as soon as they are determined to be uncollectible. An account will be determined uncollectible if over 180 days old. Accounts with credit balances that are $5.00 or less will be written off.

2. Third party claims will be pursued if not paid within 90 days after denial follow-up is complete. Any claims that are unresolved after twelve months will be written off.

RB 007 – CREDIT BALANCES AND UNAPPLIED CASH

A. Handling of Unapplied Cash

1. Client payments will be applied to client receivables from oldest date of service forward upon receipt.

2. Payments received for specified accounts, for which there is not a sufficient receivable amount to apply the payment in full will be designated as unapplied cash.

3. The balance in Unapplied Cash accounts will be reviewed on a monthly basis to determine if it may be applied to the Client Receivable in that period. Unapplied Cash amounts will be posted to Self pay Receivables prior to any new receipts of payment by the Client. Programs may be responsible for assisting in research of client accounts to determine disposition of unapplied self pay payments.

4. Unapplied Cash balances for which there are no additional Receivables posted within 120 days from the date of deposit will be refunded to the Consumer.

B. Unapplied Third Party Payments

1. Unapplied Third Party payments will be reviewed monthly for credit refunds, claim adjustments or voids.

2. Payments identified to be refunded to payers will be processed for a credit refund.

3. Claims will be adjusted or voided for payments received in error from third party payers who require such claims for payment retractions and corrections.

RB 008 CONFIDENTIALITY

Confidentiality is addressed in the District 19 CSB Human Rights Plan and in the Records Management Policies and Procedures. As applicable to the Reimbursement function, all consumer financial records are confidential and may be released only with the written permission of the consumer, responsible financial party, or other authorized representative, except as otherwise permitted by law.

Disclosure may be made to any full or part time employee, consultant, agency, or contractor of District 19 CSB to the extent required for the provision of treatment of the consumer and to obtain reimbursement for the costs of treatment.

Disclosure may be made to third party payers in accordance with Section 37.1-226, et seq. of the Code of Virginia, 1950, as amended.

Disclosure may be made to other persons authorized by the Executive Director if the disclosure is necessary to enable authorized persons to conduct the following: licensure/accreditation reviews; hearings; investigations; statistical reporting; or similar activities authorized by the Executive Director.

RB 009 RECORD MAINTENANCE AND RETENTION

Accounts receivable records will be maintained in conformity with generally accepted accounting principles and in compliance with related legal and contractual provisions. Such records will be retained in accordance with the schedule for retention and disposition authorized by the Virginia State Librarian for county and municipal governments.