

# DIVISION OF MENTAL HEALTH SERVICES

## Administrative Bulletin 7:19

EFFECTIVE DATE: 03/12/97

SUBJECT: Insurance Screening

### I. PURPOSE

New Jersey law establishes the client's liability for the total cost of care and maintenance for receiving services from a State psychiatric hospital. Some clients have insurance coverage which can reduce or eliminate their debt. The purpose of this Administrative Bulletin is to establish policy, procedures and responsibility to obtain insurance information, certify coverage for the admission where required, and bill the insurance carrier for the maximum allowable coverage.

### II. SCOPE

This Bulletin applies to all Division of Mental Health Services institutions.

### III. DEFINITIONS

The following terms, when used in this Bulletin, have the meanings indicated:

Childrens' Crisis Intervention Services (CCIS) means a Division of Mental Health Services designated acute child and adolescent inpatient psychiatric unit located in a hospital or free-standing facility which provides screening, stabilization, assessment, and short term intensive treatment for voluntary and involuntary patients.

Client means an inpatient or resident of a State psychiatric hospital.

Facility means a State psychiatric hospital or institution.

Health Maintenance Organization (HMO) means a company which contracts with a group of doctors and hospitals to treat patients for a set range of fees.

Insurance Carrier means a company which pays for medical services.

Managed care means a process of controlling the way individuals receive health care in order to reduce costs and improve quality.

Managed care organization means an organization responsible for evaluating members' health care needs (including mental health and substance abuse needs), matching needs with appropriate resources, acquiring and managing the care, paying for the care, and coordinating mental health/substance abuse services with physical health care.

Pre-certification means the act of guaranteeing prior to admission that an insurance carrier will pay for hospitalization in accordance with the member's policy.

Post-certification means the act of guaranteeing after admission (usually within 24 hours but no later than 48 hours) that an insurance carrier will pay for hospitalization in accordance with the member's policy.

Provider means a professional or organization such as a physician, hospital or clinic that furnishes healthcare services.

Screening center means a hospital or clinic which provides emergency care or crisis intervention services, and links clients to available and necessary psychiatric and physical care. Centers are designated by the Division of Mental Health Services, are charged with responsibility for involuntary commitments, and must comply with Division regulations.

Short term care facility (STCF) means a facility which provides acute involuntary inpatient psychiatric care for a brief period of time, usually 14 days or less, but no more than 30 days. STCFs are designated by the Division of Mental Health Services and must comply with Division regulations.

Supervisor of Patients Accounts (SPA) means the manager of the State facility's maintenance support program.

Third party payer means any person, company, insurance carrier, or government entity that is liable to pay all or part of a client's hospitalization costs.

#### IV. POLICY

- A. In hospitals which have an Admissions Unit, that Unit shall document upon admission which clients have insurance by asking screening center, STCF, prison, or CCIS staff and recording the response on a screening form. A suggested sample is attached. Where the insurance carrier requires certification of the admission, the hospital

Admissions Unit shall encourage the screening center to obtain that certification. If the screening center has not done so, the Admissions Unit shall post-certify the admission. If the carrier denies certification, the screener shall provide documentation to that effect. In the specialty hospitals without an Admissions Unit, the SPA shall work with the admitting physician to maximize pre or post-certifications as described above.

- B. In the event that Admissions fails to establish insurance status, hospital Social Services staff shall ask the client whether there is insurance that might cover the hospitalization.
- C. In consultation with Social Services staff, the SPA Office staff may also attempt to determine from the immediate family whether the client has insurance coverage for his or her hospitalization.
- D. Where coverage appears to exist, the SPA Office shall bill the insurance carrier within the limits of the policy and shall appeal any questionable denials or underpayments.
- E. Hospital staff should be aware that providing clinical client information to insurance carriers does not violate confidentiality guidelines. This should be limited to only that information necessary to pay a specific claim.

#### V. PROCEDURES

- A. During pre-admission contact with the screening center, CCIS or STCF, the Admissions staff shall request information on existing insurance coverage and shall document the information on a screening form or similar document (sample attached).
- B. When coverage requiring pre-approval appears to exist, Admissions staff shall ask the screening center to contact the insurance carrier and pre-certify the admission into the State hospital. If the screening center cannot pre-certify the admission, Admissions staff shall document the reason why on the screening form.
- C. If pre-certification appears necessary and has not occurred, Admissions staff shall contact the insurance carrier within 24 hours (but no later than 48 hours) of admission and attempt to post-certify the hospitalization.
- D. Admissions shall provide the SPA Office with a copy of the client admission form or screening form that contains insurance information, including the pre or post-certification number where required. Once

the patient is assigned to a treatment team, the SPA Office in turn shall notify the team about the existence of insurance coverage. The team should also be notified as to the results of the insurance billing, as it could affect discharge planning and the patient's financial obligation.

- E. Where required by insurance carriers, the hospital's Utilization Review or Medical Records Unit shall provide whatever information is necessary to document and certify clinical necessity of the admission. This should be limited to only that information necessary to pay a specific claim.
- F. The SPA Office shall submit a bill (form UB-92) to the insurance carrier in accordance with the terms and limits of the insurance policy. It shall further pursue through the appeals process any denials or underpayments which it considers improper.
- G. The SPA Office shall periodically provide Admissions with a list of names and phone numbers of HMOs, managed care agencies, and any other insurance carrier which is likely to require certification of an admission.
- H. The SPA Office shall employ a clinically appropriate written and documented mechanism to notify the patient through his or her treatment team about the result of billing the insurance claim.

APPROVED: \_\_\_\_\_



Alan G. Kaufman, Director

DATE: \_\_\_\_\_

3/12/97

Detainer: \_\_\_\_\_ Charges: \_\_\_\_\_

Screened Certif: \_\_\_\_\_ ETA Date: \_\_\_\_\_ & Time: \_\_\_\_\_

**PRE-ADMISSION TELEPHONE SCREENING FORM**

1. Call Date \_\_\_\_/\_\_\_\_/\_\_\_\_ 2. Time: \_\_\_\_\_ AM \_\_\_ PM \_\_\_

3. SS#: \_\_\_\_\_ 4. Insurance: \_\_\_\_\_

**5. Client/Patient Identifying Information:**

Marital Status: \_\_\_\_\_ Education: \_\_\_\_\_ Race: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

6. Patient's Name: \_\_\_\_\_

7. Street Address: \_\_\_\_\_ 8. City: \_\_\_\_\_

9. County: \_\_\_\_\_ 10. State: \_\_\_\_\_

11. Military Services:  Yes  No 12. Service Connected: \_\_\_\_\_

13. Name of Caller: \_\_\_\_\_ 14. Screening Center: \_\_\_\_\_

15. Telephone #: ( ) \_\_\_\_\_

**Family/Friend Contact:**

16. Name: \_\_\_\_\_ 17. Street Address: \_\_\_\_\_

18. City: \_\_\_\_\_ 19. State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

20. Relationship: \_\_\_\_\_ 21. Telephone #: ( ) \_\_\_\_\_

**Reasons for Referral:**

22. Describe the presenting problem(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Specify Alternatives Exhausted: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. Specify Past Psychiatric History: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. Past Medical History Condition: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

26. Medical Clearance: :  Yes  No 27. Doctor: \_\_\_\_\_

28. Medication Administered:  Yes  No  
A. Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_  
B. Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_  
C. Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

29. Specify Laboratory Test(s):  Yes  No

30. Specify Laboratory Test(s) Administered and Test Results:  
A. Name of Test: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
B. Name of Test: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
C. Name of Test: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

31. Type of Commitment: \_\_\_\_\_

32. Detainer:  Yes  No

33. Comments: \_\_\_\_\_  
\_\_\_\_\_

VS: T: P: R: BP: Psychiatrist:

34. Allergies: \_\_\_\_\_  
\_\_\_\_\_

35. History of Drugs/Alcohol: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Taken By: \_\_\_\_\_