SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY

NUMBER: BA171

NAME: **COMMERCIAL INSURANCE BILLING POLICY**

INITIAL APPROVAL DATE:	05/25/1995	BY: Sanilac CMH Board
(LAST) REVISION DATE:	06/11/2024	BY: Admin Supervisor – Billing/Finance
(LAST) REVIEW DATE:	08/15/2024	BY: Policy Committee
DISCONTINUED DATE:	N/A	REPLACED BY: N/A

I. PURPOSE

The purpose of this procedure is to establish a uniform method for the billing of services and the collection of fees, as well as to establish and maintain account receivable records for individuals we serve and agency receivable control accounts.

II. APPLICATION

Populations: **ALL**
Programs: **Direct - ALL**
Contracted - ALL

III. PROCEDURE

A. All providers of service will complete service activity logs or enter their activity into the Agency's EMR (electronic medical record). The service activity logs will contain the name of the individual served, Agency program, case number, date of service, authorization number, staff/contract employee name and provider number, HCPCS/CPT code, start time elapse time and contact type (face to face, etc.). These logs are used in the Agency's EMR for billing purposes.

B. The EMR will be used to generate the necessary 3rd party claims for submission electronically (or in hardcopy form) to all commercial insurance companies in a timely fashion.

C. If the individual served has any insurance coverage, this will be entered on the individual's account in the Agency's EMR. The clerical/front desk agency staff will ask the individual for their insurance card(s) and will scan a copy of the front and back of the card to the billing email account.

D. An accounts receivable ledger will be maintained on all individuals served in the Agency's EMR.

E. Uniform billing and collection procedures will be followed.

F. Claim submission will be in accordance with MDHHS policy and procedures. The MDHHS Behavioral Health Code Chart is referenced and utilized for coding of services provided. This workbook is the source document used to incorporate multiple service code and modifier information sources into one document to facilitate access to key information needed in support of capturing services provided to MDHHS beneficiaries. [https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting]

G. All payments from insurance companies and individuals served will be entered into the Agency's EMR when received. Checks (or cash) will be given to the Finance Department for deposit into the Agency's bank account.

H. All rejections from insurance companies will be investigated by the Billing Specialists. The claim(s) will be corrected and re-billed in a timely manner or adjusted based on the findings.

I. All account write-offs (excluding insurance adjustments due to allowed amounts, service not covered, provider not eligible to be enrolled, provider not enrolled yet, etc.) must be approved by the CFO.

J. All appropriate staff shall be enrolled in any applicable insurance panels (verifying appropriate credentials are in place and current) in order to maximize the Agency's ability to bill for services rendered. The Data Management Specialist will enroll the degreed and licensed clinicians/providers in all applicable insurance panels in a timely manner and will keep the insurance rosters up to date (remove past employees and add new employees that are able to be enrolled). A Billing/Finance staff person will complete the enrollments for Medicare, OPTUM/VACCN and CHAMPS in a timely manner. The Billing/Finance staff person will keep the insurance rosters up to date for Medicare, OPTUM/VACCN and CHAMPS (remove past employees and add new employees that are able to be enrolled.