

Administrative Guide

Introduction

This section is devoted to the administrative aspects of working with PBH. This section may repeat information already located in other areas within the Provider Manual. We recommend that providers distribute this to all administrative staff within their offices. This section is a step-by-step tool aimed at easing the administrative processes.

PBH recognizes the important role administrative personnel play. They are often the first contact with a practitioner office. PBH is committed to offering quality care to our members. Administrative training plays a key role in achieving this standard.

Section Highlights

- ◆ *Provider status/office change procedure*
 - ◆ *Referral process*
 - ◆ *Pre-Authorization Requirements*
 - ◆ *No-show Policy*
 - ◆ *Clinical Documentation Requirements*
 - ◆ *Prescription and Laboratory Procedures*
 - ◆ *Billing process*
 - ◆ *HCFA 1500 Form Required Information*
 - ◆ *Coordination of Benefits*
 - ◆ *Coordination of Care*
-

Communicating Changes

Moving your office? Adding a location? PacifiCare Behavioral Health requests that network providers notify the Provider Network Management Department of changes within their practice. **Practice changes** include:

- ◆ Change of office address or phone number
- ◆ Addition or deletion of an office location
- ◆ Change of mailing address
- ◆ Change of emergency phone or pager numbers
- ◆ Change of tax ID number or check payable name

To make a change for one of these reasons, providers must complete the Change of Address/ Information form on the next page and fax it to the listed number.

As part of our commitment to quality customer service, PBH requests that providers assist us in maintaining the current status of their practice.

Status changes to notify PBH Provider Network Management about:

- ◆ Maternity leave
- ◆ Extended vacations/illnesses
- ◆ Restrictions in referrals (e.g. not accepting new members)
- ◆ Availability (e.g. evening, weekend)

Status changes can be made by calling the PBH Provider Helpline at (800) 716-1166.

Change of Address/Information

(Please type or print legibly)

Old Information:

Name _____

Current Address _____

Change To:

Name _____

Address _____

Mailing or Service (Please circle one)

2nd Address _____

Mailing or Service (Please circle one)

Phone (include area code) _____

Office _____

Checks Payable To* _____

Tax ID Number _____

Effective Date _____

Signature _____

Please return to PacifiCare Behavioral Health
ATTN: Provider Network Management
See Quick Reference Guide in Region Specific Information
for Address and Fax

*If payment is to an entity other than the provider of service, a third party payor agreement is required. This form may be requested by calling the Provider Helpline at (800) 716-1166.

How a Member is Referred to a Provider

- 1) The member calls PacifiCare Behavioral Health directly at the designated (800) number.
- 2) The clinical services representative gathers basic demographic information, verifies eligibility and determines the type of services the member is seeking.
- 3) The clinical services representative conducts a brief assessment. The member is asked about:
 - ◆ Severity of the problem/symptoms
 - ◆ How the problem may be affecting aspects of the member's life
 - ◆ How the problem relates to past experiences
- 4) The PBH clinical services representative matches the member with an appropriate group practice or individual provider based on the member's needs, geographic location and the Medical Necessity of the situation.
- 5) The member is referred to a PBH network provider, who is authorized for a specific number of visits over a specified period of time.
- 6) PBH notifies the provider by telephone of the referral and services authorized, and an authorization form is subsequently mailed to the provider.

Remember This About PBH Referrals

- ◆ *All services (including psychological testing) must be pre-authorized. Services will not be reviewed retroactively. Make sure your members have contacted PBH prior to your appointment.*
 - ◆ *Once the initial referral has been made, it is the provider's responsibility to obtain further authorization.*
 - *Pre-Authorization = Claims paid (according to benefit limitations and exclusions)*
 - *Failure to pre-authorize service = Denial of claim*
 - ◆ *All services are to be provided by the PacifiCare Behavioral Health credentialed/contracted provider named on the authorization.*
 - ◆ *If you have not received a telephone call notifying you of a referral, contact the PBH Helpline listed in the Quick Reference Guide for verification of referral.*
 - ◆ *Primary care physicians may contact PBH to make a referral for one of their members.*
 - ◆ *Written authorization forms will arrive within one week of referral. Contact PBH if you have not received your authorization.*
-

No-Show Policy Recommendations (Behavioral Health Benefit)

This section applies to PBH network practitioners who provide services to a member under their managed care benefit plan. The provider may bill the member for the missed appointment if the practitioner has reviewed his/her No-Show Policy in advance with the member and if the member fails to notify the provider 24 hours prior to the missed appointment.

- ◆ Review your No-Show Policy at the time of your first appointment
- ◆ Give specific instructions to the member about who he/she should call to cancel the appointment
- ◆ Have the member sign a written form acknowledging that you have verbally explained your policy of requiring 24 hours notice for canceled appointments
- ◆ The member is to be notified that he/she will be financially responsible at the PBH rate for no-shows and late cancellations
- ◆ If a member misses two appointments, you have the option to refer the member back to PBH if you choose not to reschedule them
- ◆ PBH does not routinely reimburse providers for patient no-shows.

On the next page is an example of an agreement form which you may use if you desire.

No-Show Sample Form

This is a sample form you may use for PacifiCare Behavioral Health members:

DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELED APPOINTMENT

I understand and agree to the following:

1. It is my responsibility to notify:

Name _____

Phone number _____

24 hours prior to the scheduled appointment if I am unable to keep the scheduled appointment.

2. I agree that I will be billed the PBH contracted rate of _____ in the event that I miss an appointment or fail to cancel 24 hours prior to the scheduled appointment.

Patient

Practitioner

Date

Clinical Documentation Requirements

Although the responsibility to submit the appropriate documentation belongs to the provider, it is important for administrative personnel to understand the process.

Administrative personnel need to have an awareness of the authorization process and its relation to the billing system within their offices. Failure to receive proper Pre-Authorization results in denial of claims.

Individual practitioners are required to submit the following basic forms to PBH:

- ◆ The Provider Assessment Report (PAR) should be used to request authorization for additional services. In addition, the PAR should be used as a discharge summary for brief treatment episodes that are completed with the number of visits authorized. The PAR has a field, “Treatment Terminated” which when checked and “00” additional sessions are requested, the PAR becomes a Discharge Summary. There is no need to submit any form upon completion of longer episodes of care, as sufficient clinical data has already been collected during the telephonic review process.

- ◆ LSQ/YLSQ

The *Health Care Coordination Form* needs to be completed for all members seen and mailed to the primary care physician (PCP).

Providers requesting authorization for psychological testing are required to submit the PBH Request for Psychological Testing Authorizations form to PBH. (See Provider Guidelines, Specialized Service Procedures section for more information on psychological testing authorization requests).

You will find sample forms in the Index of Forms section of this manual.

PBH Outpatient Prescription and Laboratory Policies

Clinicians with prescriptive authority should remember:

- ◆ PBH benefit plans do not cover medications. PBH is not responsible for determining which medications will be covered under a specific formulary.

- ◆ For PBH members who also have PacifiCare medical insurance, providers may request a fax copy of the PacifiCare Health Systems outpatient drug formulary by calling (800) 527-0531.
- ◆ PBH recommends that providers work with members to review the procedure for coverage of medications under their medical plan.
- ◆ Laboratory tests for medications may require coordination with the primary care physician or medical group.

PBH providers can contact the Provider Helpline at (800) 716-1166 for assistance with medication benefit issues.

Billing, It's As Easy As . . .

PacifiCare Behavioral Health is committed to prompt and accurate claims payment. In order to achieve this result, PBH relies on providers to submit accurate claims.

The PBH claims system is rule-based. This means payment of claims relies heavily on whether or not the claim form fulfills the rules for payment. The process is very simple, if you remember these things:

Pre-Authorization

All services (including psychological testing) must be pre-authorized in order to receive payment. Services billed must match services authorized by:

- ◆ Service type (diagnosis and procedural)
- ◆ Valid service dates
- ◆ Number of authorized services
- ◆ Tax ID of provider performing services

Accurate and Complete Claim Forms

To ensure timely, accurate payment, all practitioner bills must be submitted on HCFA 1500 forms. All required information for the HCFA 1500 form is addressed on the next page. Facilities must submit bills on UB92 forms.

Timely Claims Submission

All claims must be submitted within 90 days from the date of service.

Facility bills must be held until the fully authorized course of treatment has been completed and the member has been discharged or has discontinued authorized treatment. The fully authorized course of treatment includes all extensions and transfers to different levels of care within the facility.

Required Billing Information For HCFA Form 1500

The following fields are **required** to be filled in to insure expedient claims processing. Fields for which we have provided more detailed explanations are particularly important. Please make sure that you or your billing representative have a thorough understanding of the data required.

1a. Insured's I.D. Number

Member's PacifiCare Behavioral Health identification number.

2. Member's Name

3. Member's birth date

4. Insured's Name

This is the individual who is the policyholder with PacifiCare Behavioral Health.

5. Member's Address

6. Member Relationship to insured

7. Insured's Address

12. Medical Release

13. Payment Authorization

21. Diagnosis or nature of illness

Primary diagnosis must be from the most current printing of the DSM-IV.

24. A. Dates of Services

B. Place of Service

C. Type of Service

D. Procedures, services, or supplies

CPT code which best represents authorized services. Must be code recognized in most current standard edition of AMA's CPT reference book.

E. Diagnosis Code

F. Charges

G. Days or units

25. Federal Tax ID number or Social Security Number.

This number reflects what will be reported in the 1099 mailed to you each January for previous year's reimbursements.

26. Member's Account No.

27. Accept Assignment

28. Total Charge

29. Amount Paid

30. Balance Due

31. Signature of Physician

Your signature and date NEEDS to appear in this box. If you are using a xerox copy of the HCFA form, please sign in blue ink.

32. Name and Address of facility where services were rendered (other than home or office)

33. Physician's billing name, address, zip code and phone number.

Your name and the address to which payment/communication is to be sent. If this information has changed since you were credentialed, please notify Provider Network Management to avoid processing delays

Reimbursement Issues

- ◆ All claims should be submitted within 90 days from the date of service to avoid denial of the claim.
- ◆ It is important when submitting claims to complete the member's and insured's name, PBH member identification number and the name of the subscriber's employer.
- ◆ When the member is a dependent of a PBH insured, PBH will be requesting other insurance information from the insured. **This may delay the processing of the claim.** When PBH is secondary and no EOB from the primary carrier is attached to the claim, the PBH EOB will state that the claim has been denied. The provider can resubmit the claim with the appropriate EOB.
- ◆ Claims must be re-submitted to the PBH Claims Department within 30 days of the denial.
- ◆ Providers may not balance bill PBH members.

Submission of Claims

- ◆ Be sure to include all information listed in the Required Billing Information section.
- ◆ Submit claims to one of the following post office boxes:

Orange County Medi-Cal Claims Only: PacifiCare Behavioral Health, Inc.
P.O. Box 31052
Laguna Hills, CA 92654-1052

NON-Medi-Cal CLAIMS: PacifiCare Behavioral Health, Inc
P.O. Box 31053
Laguna Hills, CA 92654-1053

- ◆ Incomplete or inaccurate claims will result in unnecessary delays in payment or in claims being returned. Your cooperation in the PBH claims system assures you of timely claims payments and accurate and specific data collection by PBH which is fairly and appropriately represented to its clients and providers in re-negotiations.
- ◆ Any questions regarding the approval and/or payment of claims should be directed to the Provider Helpline during business hours at (800) 716-1166.

Electronic Claims Submission

PBH is moving forward in our efforts to make available to providers electronic interfaces for claims submission. These include clearing houses, claims diskette submission and the use of the Internet. Currently monthly claims diskette submission is available for providers who wish to utilize this option. Use of clearing houses and the Internet should be available some time in the year 2001. For more information, please call the Provider Helpline at (800) 716-1166.

How to Get PacifiCare Behavioral Health to Pay You Faster

PBH wants to pay you quickly for the services you provide to members. You can help by following these simple guidelines when completing a universal claim form or submitting a bill:

- ◆ Use CPT codes or service type/room type codes for all provider services
- ◆ Your primary diagnostic code must be from the DSM-IV; failure to include this code will result in delay of payment
- ◆ **Please note that PBH will not accept code 799.90 or diagnosis deferred**
- ◆ For inpatient, residential and partial hospitalization programs the number of days should be broken out by the level of service
- ◆ Include the member's name, address, date of birth and PBH member identification number
- ◆ Include assignment of benefits, if appropriate
- ◆ Indicate the place of service according to the codes below and the service code listed on the authorization

Place of Service Codes

The following are the place-of-service codes to be used on the universal claim form or when submitting a bill:

- 11 Office
- 12 Home
- 20 Inpatient practitioner visit

- 21 Inpatient hospital
- 22 Outpatient hospital
- 23 Emergency room – hospital
- 24 Emergency room – free standing ambulatory centers
- 25 Birthing center
- 26 Military treatment facility
- 31 Skilled nursing facility
- 32 Nursing facility
- 33 Custodial care
- 34 Hospice
- 41 Ambulance – land
- 42 Ambulance by air or water
- 51 Inpatient psychiatric facility
- 52 Psychiatric facility partial hospitalization
- 53 Community mental health center
- 54 Intermediate care
- 55 Residential substance abuse treatment facility
- 56 Psychiatric residential treatment center
- 61 Comprehensive inpatient
- 62 Comprehensive outpatient
- 65 End stage renal
- 71 State or local public health clinic
- 72 Rural health clinic
- 81 Independent laboratory
- 99 Other unlisted facility

Sample of Request for Billing Information

We are in receipt of the attached claim form for behavioral health (psychiatric or chemical dependency) services and are advising you that there will be a delay in processing. Please respond to all of the items checked below so we can proceed with the claim.

Provider Information

Provider signature/licensure _____
Tax identification or Social Security number _____
Other _____

Member and Subscriber Information

Patient's name _____
Patient's date of birth _____
Date of birth (verification needed; documents submitted are in disagreement) _____
Subscriber's name _____
Subscriber' SS# _____
Subscriber's group name _____
PBH policy number _____
Copy of authorization (ALL SERVICES MUST BE PRE-AUTHORIZED THROUGH PBH)

Service Information

Procedure code for all practitioner services _____
Diagnosis code _____
Other _____

Administrative Information

Assignment of Benefits form assigning benefits to the provider _____
Originals only for billing _____
Other _____

If you have any questions regarding this notice, please contact the PBH Provider Helpline at (800) 716-1166.

No action will be taken until receipt of the requested information.

Thank You
PBH Claims Department

Form 10

Coordination of Benefits

Coordination of benefits is the practice of two or more plans coordinating their provision of health benefits to members who have multiple coverage. Currently, PacifiCare Behavioral Health benefits are subject to the COB provision. You will find sample documents addressing COB issues in this manual.

Although many of the specifics regarding COB are not relevant to the provider, there are some that pertain to Pre-Authorization and primary coverage determination.

Pre-Authorization

Under the PBH COB provision, it is necessary to pre-authorize services at all times, even in the event that PBH is secondary. Failure to pre-authorize could result in denial of payment.

Primary versus Secondary Determination

Dependent Child (Parents Not Separated or Divorced)

- ◆ PBH applies the “birthday rule” when determining primary coverage. (i.e., for dependent children, the plan of the parent whose month and day of birth occurs earlier in the calendar year is primary)
- ◆ If one plan does not follow the birthday rule, then the rules of the plan which does not have the birthday rule provision shall be primary

Dependent Child (Parents Separated or Divorced)

- ◆ If the parent with custody has not remarried, the plan of the parent with custody is primary over the plan of the parent without custody
- ◆ If parents are divorced and the parent with custody remarries, the plan of the parent with custody is primary over the plan of the stepparent; the non-custodial parent’s plan would be tertiary
- ◆ If a court decree establishes financial responsibility for health care expenses, then the plan of the parent with such responsibility shall be primary

See sample form on next page: COB Dependent Inquiry

Sample: COB Dependent Inquiry

DEPENDENT

CF# _____

In an effort to update our records of the above-named patient, please fill out the information below and return as soon as possible.

ANY MISREPRESENTATION REGARDING ADDITIONAL HEALTH INSURANCE COULD RESULT IN INSURANCE FRAUD. IN ORDER FOR PBH TO EFFECTIVELY MANAGE THE AVAILABLE PLAN BENEFIT, FULL DISCLOSURE OF OTHER INSURANCE COVERAGE MUST BE GIVEN AT THIS TIME.

Is the above-named dependent covered under any other behavioral health insurance plan?

Yes _____ No _____

(IF NO, DISCONTINUE AND SIGN BELOW)

Name of other behavioral health insurance company _____

City _____ State _____ Zip _____

Phone Number () _____

Group Number _____ ID Number _____

Name of primary insured under above plan _____ Birthdate _____

I certify that the above information is true and correct.

Signature _____ Date _____

If you have any questions, please feel free to call the PBH Provider Helpline at (800) 716-1166.

Thank You,
PBH Claims Department