

INSURANCE VERIFICATION AND AUTHORIZATIONS

SETTING UP INSURANCE PLANS/POLICIES AND PAYORS IN HORIZON

SUMMARY

Use the following instructions to obtain insurance verifications, to set up insurance payors and plans, admission bill sequence and to enter insurance authorizations in Horizon. Billing processes pull the information set up in **Specify Coverage Information, Customer Maintenance** to create and process billable charges. It is essential that the payor and plan information, admission bill sequence and insurance authorizations are set up correctly in the **Specify Coverage Information** icon in order to complete billing processes.

ROLES

The Clerical Staff is responsible for obtaining insurance verifications and authorizations for traditional Medicare and Medicaid patients with oversight and assistance from the Supervisor.

The Supervisor/nurse designee is responsible for obtaining insurance verifications and authorizations for any patient who will be billed through Third Party Billing and/or Medicare HMO Plans.

The Clerical Staff is responsible for setting up insurance payors for the patient and bill sequence for the patient admission in the **Specify Coverage Information** icon in Customer Maintenance.

The Clerical Staff is responsible for setting up **Insurance Authorizations** in Horizon. If authorization is required, you must enter authorization number and the number of visits in Customer Maintenance on the **Specify Authorization** tab and in a **Payor Plan Note**.

The visiting clinician is responsible to check all Insurance cards, numbers, and names when making the admission visit. The clinician will notify the clerical staff if any discrepancies are found.

The visiting clinician is responsible to inquire if the patient is currently being served by another Home Health Agency or if the patient is going to outpatient therapy.

PROCESS

INSURANCE VERIFICATIONS

Medicare Verifications

1. All Medicare verifications are completed by the designated clerical staff at the subunit through the use of E-Solutions.
 - Instructions provided by E-Solutions via the website.
 - The E-Solutions report also provides information regarding the adjacent PPS episodes.
2. Notify the supervisor/designee of any noted issues with the verification results. Proceed to set up Insurance Payors and Plans in Horizon as applicable.
3. Complete the 'For this Admission' box by entering the number of adjacent PPS episodes and the ending date of the last PPS Episode billed by another provider, if applicable.

Medicaid Eligibility

1. Check Medicaid eligibility on the Alabama Medicaid Site.
2. Obtain a User ID and password from your office ADPH Security Coordinator.
3. The ALA Medicaid Log On .url can be saved to the computer desktop so that web access is readily available.
4. Follow directions in the WEB Eligibility User Guide.
5. The WEB User Guide is available in Documents Library in Lotus Notes.

Third Party Insurance Verifications/Medicare HMO

1. The **supervisor/nurse designee** is responsible for obtaining insurance verifications and authorizations for any patients that will be billed through a third party insurance company and/or Medicare HMO.
 - Contact is to be made via the phone to validate items such as eligibility, pre authorization, co pays, etc. **Always verify if the plan is Third Party or Medicare Advantage.**
 - Alabama BCBS recommends checking patient eligibility monthly via their web site.
 - **For assistance in verification, refer to Tip Sheets listed under [Third Party Payors/Private Insurance](#) under Billing/Support on the website.**

- [Insurance Verification Form](#): Complete the top portion of Page 1 for all patients, bottom of Page 1, as well as Page 2, are for patients that we are not in contract with.
 - Fax form to Billing (**Attention: Dorothy Hall**) on all insurances that are not in contract with ADPH Home Health.
 - File in patients record.
 - Also enter insurance information in an Admission Note with the note type of 'Payor Plan Note.' Make sure to note the rate, any applicable co-pays, and deductibles.
 - If a provider contract is needed, refer the patient to a provider in the third party payor's provider network or contact the Home Health Manager/Director to begin proceedings to become a contracted provider.
 - Consult with area management to determine if referral can be accepted based on requirements of the third party payor and the payment amounts.
2. Verify insurance for Medicare Advantage patients through the insurance company that handles the Medicare Advantage policy.
 3. For Medicare Advantage patients: insure that the admitting nurse knows this patient is a Medicare managed care patient so that MO 150 can be answered correctly. (Answer 2)
 4. Insure that the admitting nurse completes the MSP questionnaire on the Referral/SOC form to correctly determine the primary payor.
 5. The subunit supervisor is responsible for discussing the patient's insurances with the admitting nurse and insuring that the bill sequence is set up correctly.

SETTING UP PAYORS AND INSURANCE PLANS

NOTE: ** IMPORTANT Insurance coverage is maintained at the customer level and not the admission level. The plan only has to be entered one time per patient. Only end date a plan if the patient no longer has the insurance. Do not re-enter the plan or insurance coverage information (if unchanged) with each subsequent admission. The Bill Sequence tab is where the admission specific payor information is set.**

1. After coverage information is verified, enter or check the payor information in the **Specify Coverage Information** icon in **Customer Maintenance**.
2. From the **Horizon** main menu, go to **Customer Maintenance**.
3. Use the **binoculars** to select the patient.

4. Click on the **Specify Coverage Information** icon.
5. The **Specify Coverage Information** screen opens.
 - **Current Customer:** Box at the top of the screen that displays the patient selected in the **Select Customer** screen.
 - The next box holds the patient admissions.
 - If this is the first admission for the patient, the box will only contain the admission just established.
 - If there are prior or current admissions, they all will be listed showing the **ID, Episode Type, Begin Date, End Date and Org Level**.
 - Highlight blue the row with the admission that you want to work with.
 - Below the patient admissions box is the **Policies** box. All prior policies (insurance plans and payors) entered into Horizon will be displayed in this section.
 - If this is a new patient to 'Horizon' no policies will be present.
 - If this is a new patient to Home Health but the patient is a prior or current Biomonitoring patient, the plan that covers Biomonitoring will be listed in the **Policies** box.
 - Below the **Policies** box is a section of tabs where new policies/plans are added and other billing information is entered
 - The three tabs the subunits will be using are **Policies, Pol Holder (Policy Holder, and Bill Seq (Bill Sequence)**.
 - The bottom of the screen contains a section that displays Admission Referral Notes.
 - Information on payors and plans should be listed here.
6. If the policy or coverage information has previously been entered, it does not need to be entered again. Verify that the policy/coverage information is present and then go to 'Setting Up Bill Sequence'.
 - A policy or coverage information should never be end dated unless the patient no longer has that coverage.

ADDING A INSURANCE POLICY, PLAN OR COVERAGE INFORMATION

1. If the patient is new to Horizon or the payor or coverage information has never been previously entered, add the coverage information under the **Policy** tab.
2. To add a new policy/coverage, click on the **New** icon from the **Policy** tab in the **Specify Coverage Information** screen.
3. The **Specify New Policy** window appears with the customer name in the current customer box.

- Use the **binoculars** to search for the payor/plan for this episode. Type the plan name in the **Position** box to narrow the search. **Highlight** the plan name then click **OK**.
 - Use the drop down calendar to select the **Coverage Begin Date**. If the coverage is in effect when the admission begins, use the admission date as the coverage Begin Date.
 - Leave the **Coverage End Date** field blank.
 - Click **OK**.
4. The new plan appears in the grid above the tabs.
5. **Highlight** the row of the newly created plan.
6. Click on the **Policies tab**. Information previously entered in Horizon will populate in appropriate fields. Enter the required information using the following as a reference:
- **ID Number**: Enter the policy ID number. Enter the social security number for customers without a specific ID number.
 - **Coverage Begin Date**: Defaults to the date policy was entered.
 - **Coverage End Date**: Leave blank unless certain the policy coverage has ended.
 - **Group Name**: Leave blank, except for private insurance payors. Enter the Group Name if applicable for private insurance.
 - **Group Number**: Leave blank, except for private insurance payors. Enter the Group Number for private insurance as applicable.
 - **EGHP**: Check this box if this policy is an Employee Group Health Plan for Private Insurance Payors.
 - **Release Med Info**: Use the drop down to select **Y** (yes), allowed to release data.
 - **Benefits Assigned**: Click this box. A check will appear.
 - **Deductible Met**: Check this box for Private Insurance Payors if the patient has paid their deductible for the year.
 - **Eligible**: Enter the beginning eligibility date for the policy for Private Insurance Payors.
 - **Verification Status**: Use the drop down to select **VC** (Verified Coverage) for all customers admitted to the program once the coverage has been verified.
 - **Date**: Enter the date insurance was verified. May use the admission date.
 - **User**: Use the binoculars to select the name of personnel entering the information.
 - **Policy Mgr/Plan Mgr**: Leave blank. Information will default from Plan Information if entered.
 - For customers with multiple plans, repeat steps 5 thru 9 for each plan.
 - See the **Medicare Secondary Payor** instructions for patients who have Medicare as a secondary payor.

7. Click on the **Pol Hol** tab to **bring** it forward. (**Policy Holder**).
 - Review the information. If the policy holder is other than the party listed, use the binoculars to search for the **Related Party**. Complete information as for the **actual policy holder**. **Begin Date** is required. (Use the drop-down calendar to select the date. Use the oldest start of care date as the begin date.
 - The policy holder pre-populates with the patient's name. Always check to see if this is accurate or if it needs changing to a related party.

SETTING THE BILL SEQUENCE

1. A billing sequence must be set on every admission for billing purposes. **Note: We no longer have to include Medicare or Medicaid in the bill sequence in order to get the numbers to populate to the OASIS.**
2. Do not set up the Bill Sequence until all insurances have been verified and the admitting clinician has verified information on the policy cards. The supervisor in conjunction with the admitting clinician will determine the payors for the admission.
 - Consult with the Billing Support Representative if the patient has multiple insurances and there are questions regarding primary and secondary payers.
3. In the box that list admission, highlight blue the admission that you are working with.
4. Click on the **Bill Seq** tab to bring it forward (Bill Sequence).
5. Click on the **New** icon to add the new sequence. The **Specify New Effective Date Range** screen appears.
 - Use the drop down window to enter the **Effective Date** for the billing sequence.
 - The effective date needs to be the admission/start of care date.
 - This defaults to the current date, change if appropriate.
 - Leave the effective thru date blank unless you know for certain the insurance coverage has a definite end date.
 - Click **OK**.
6. The effective date now appears in the **Effective Date Range** box on the left side of the screen.
7. Highlight the primary coverage/insurance plan from the policies box. You will see yellow dots around the selected plan. Press the **Control** key and **A** key at the same time. The new plan will appear in the billing sequence. The primary insurance should appear as order 1.
8. Repeat this process to bring each eligible payor/plan into the **Billing Sequence**.

9. The **Plan ID, Plan Description, and the Plan Sequence** will populate to the **Bill Sequence** box and can't be changed.
10. The data in the **Bill Sequence and Bill Proportion** columns are blue and can be changed as needed to bill correctly.
 - Leave the Bill Proportion as defaulted unless directed otherwise for specific situations. (See MSP instructions)

PAYOR SPECIFIC BILL SEQUENCE INSTRUCTIONS

Medicaid Bill Sequence

1. Medicaid Home Health will be plan No. 1 in the bill sequence for Medicaid admissions that have no other coverage.
2. Medicaid will only pay up to a total of 104 visits a year. In order to continue to process services when the 104 visit limit is reached, a roll over plan is available to use for Medicaid patients.
3. Add the new plan when needed to get services to process through Enter Services or when the Expiring Authorization report indicates that the roll over plan will be needed.
4. From the 'Policies' tab, select the 'New' icon and add the Plan ID, "**OVER VISIT INDIGENT**". Plan Description: "**CAID OVER VISIT INDIGENT**"
 - Use the SOC date as the 'Coverage begin date.'
5. Leave the policy ID number, group name and group number blank.
6. Complete the Release Med Information, Benefits Assigned, and Verification Status using the previous directions.
7. When the policy information is entered, proceed to set the Bill Sequence.
8. The '**OVER VISIT INDIGENT**' should be added as Bill Sequence 2. It is labeled:
 - Plan Description: **OVER VISIT INDIGENT**
 - Plan ID: **CAID OVER VISIT INDIGENT**
9. Using the Plan, 'CAID OVER VISIT INDIGENT' in the Bill Sequence, will allow all services to be processed in Enter Services and will allow for tracking of patients who exceed the 104 visits a year.
10. See following screen shot:

Customer Maintenance - (Specify Coverage Information)

Customers Processes Help



Current Customer:

Episode ID	Episode Type	BegDat	EndDat	Organizations	Clinical
▶ 00100661	Medicaid Unskilled	08/17/2011		ADPH / AREA 01 / 47	<input checked="" type="checkbox"/>

Policies:

Plan Seq	Plan ID	Plan Description	Cvg Begin	Cvg End
▶ 2	MEDICAID HH	MEDICAID HOME HEALTH	07/13/2011	
1	MEDICARE A	MEDICARE A	01/28/2011	

Policies | Pol Holder | **Bill Seq** | Bill Hold & Rel | Coverage | Dia/Surg | Bill Codes | Add'l Bill Codes | Req Docs

Effective Date Ranges		Billing Sequence (Press Ctrl-A to add a Policy)				
Begin Date	End Date	Bil Seq	Plan ID	Plan Description	Bill Prp	Plan Seq
▶ 08/17/2011		▶ 1	MEDICAID HH	MEDICAID HOME HEALTH	1.0000	2
		2	OVER LIMIT IND	CAID OVER LIMIT INDIGENT	1.0000	3

Admission Referral Notes

Content: Subject:



Medicaid Secondary Payor Patients Medicaid Patients Who Have Other Private Insurance

- Alabama Medicaid now requires that all private insurances, a patient may have, be billed for services prior to billing Medicaid.
 - This applies to services that we know will not be covered by the other insurance such as Home Health Aide services.
 - We must obtain a denial from the private insurance prior to billing Medicaid.
- Patients that have Medicaid as well as other private insurance will need to have a bill sequence that list Medicaid as a secondary payor.
- See example:

Customer Maintenance - (Specify Coverage Information)

Customers Processes Help

Current Customer:

Episode ID	Episode Type	BegDat	EndDat	Organizations	Clinical
00096022	Home Health Other	03/22/2011		ADPH / AREA 02 / 42 / 42HH	<input checked="" type="checkbox"/>

Policies:

Plan Seq	Plan ID	Plan Description	Cvg Begin	Cvg End
1	BLUE CROSS AL	BLUE CROSS BLUE SHIELD OF ALABAMA	03/21/2011	
2	MEDICAID HH	MEDICAID HOME HEALTH	03/21/2011	

Policies | Pol Holder | **Bill Seq** | Bill Hold & Rel | Coverage | Dia/Surg | Bill Codes | Add'l Bill Codes | Req Docs

Effective Date Ranges		Billing Sequence (Press Ctrl-A to add a Policy)				
Begin Date	End Date	Bil Seq	Plan ID	Plan Description	Bill Prp	Plan Seq
03/21/2011		1	BLUE CROSS AL	BLUE CROSS BLUE SHIELD C	1.0000	1
		2	MEDICAID MSP	MEDICAID SECONDARY PAYOR	1.0000	3

Admission Referral Notes

Content: Subject:

Blue Cross and Blue Shield Bill Sequence for Physical Therapy

- For BCBS private patients, who are receiving therapy services, list both Blue Cross and Blue Shield of Alabama and Blue Cross and Blue Shield of Alabama Therapy in the Bill Sequence. List BCBS of Alabama as #1 in the **Bill Sequence** and list BCBS of Alabama Therapy as #2.

Customer Maintenance - (Specify Coverage Information)

Customers Processes Help

Current Customer:

Episode ID	Episode Type	BegDat	EndDat	Organizations	Clinical
▶ 00095866	Home Health Other	03/17/2011		ADPH / AREA 02 / 42 / 42HH	<input checked="" type="checkbox"/>

Policies:

Plan Seq	Plan ID	Plan Description	Cvg Begin	Cvg End
▶ 2	BCBS AL THERAPY	BCBS PHYSICAL THERAPY	03/16/2011	
1	BLUE CROSS AL	BLUE CROSS BLUE SHIELD OF ALABAMA	03/16/2011	

Policies | Pol Holder | **Bill Seq** | Bill Hold & Rel | Coverage | Dia/Surg | Bill Codes | Add'l Bill Codes | Req Docs

Effective Date Ranges		Billing Sequence (Press Ctrl-A to add a Policy)				
Begin Date	End Date	Bill Seq	Plan ID	Plan Description	Bill Prp	Plan Seq
▶ 03/16/2011		▶ 1	BLUE CROSS AL	BLUE CROSS BLUE SHIELD C	1.0000	1
		2	BCBS AL THERAPY	BCBS PHYSICAL THERAPY	1.0000	2

Admission Referral Notes

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Medicare Secondary Payor Bill Sequence Instructions

Use the following process when Medicare is the secondary payor.

1. From the **Horizon Homecare** main menu, go to **Customer/Customer Maintenance**.
2. Select Specific Customer and Admission.
3. Click on the Specify Coverage Information icon.
4. If Medicare Secondary Payor is not one of the policies, add it by clicking on the **New** icon and choosing Medicare Secondary Payor. Use the previous instructions to set up the Plan.
5. Click save, to save the new plan.
6. Click on the bill sequence tab.
7. Add the MSP plan with a bill sequence of 1 and a bill proportion of zero.
8. Click on the Additional Bill Codes tab.
9. Make sure the MSP plan is highlighted and add the applicable **Medicare Secondary Type (NBUC code)** from the drop down list.
10. Save the changes when you exit the tab.
11. See example:

Medicare Secondary Payor Example:

Customer Maintenance - (Specify Coverage Information)

Customers Processes Help

Current Customer:

Episode ID	Episode Type	BegDat	EndDat	Organizations	Clinical
▶ 00096881	Home Health Other	04/12/2011		ADPH / AREA 05 / 25 / 25HH	<input checked="" type="checkbox"/>

Policies:

Plan Seq	Plan ID	Plan Description	Cvg Begin	Cvg End
▶ 1	BLUE CROSS AL	BLUE CROSS BLUE SHIELD OF ALABAMA	07/01/2003	
2	MEDICARE MSP	MEDICARE SECONDARY PAYOR	09/01/1988	03/11/2011

Policies | Pol Holder | **Bill Seq** | Bill Hold & Rel | Coverage | Dia/Surg | Bill Cgdes | Add'l Bill Codes | Req Docs

Effective Date Ranges		Billing Sequence (Press Ctrl-A to add a Policy)				
Begin Date	End Date	Bil Seq	Plan ID	Plan Description	Bill Prp	Plan Seq
▶ 04/12/2011		▶ 1	MEDICARE MSP	MEDICARE SECONDARY PAY	0.0000	4
		1	BLUE CROSS AL	BLUE CROSS BLUE SHIELD C	1.0000	1

Admission Referral Notes

Content: Subject:

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USING NOTES TO ENTER ADDITIONAL INSURANCE INFORMATION

1. Enter any additional insurance information that may be needed for future reference or needed for billing, in the **Notes** section of the medical record.
2. The **Notes icon** is available and can be accessed from most of the screens in Customer Maintenance.
3. The Notes icon is at the top on the left side of the screen. The icon has a red exclamation point.
4. Click on the Notes icon and choose **Customer/Patient Note** for the **category**.
5. Click the add button at the bottom of the screen.
6. The Add Note screen is displayed.
7. From the drop down menu, choose **Payor Plan Note** for the **Notes Type**.
8. Enter a Subject Heading in the **Subject** box.
9. Enter any additional information for future reference in the text field.
10. Click **OK** to save and exit the screen.

ADDING INSURANCE AUTHORIZATIONS

1. Complete the authorization for Home Health insurance payors:
 - Who require pre-certification before services are rendered or continued.
 - If authorization is required, you must enter authorization number and the number of visits in Customer Maintenance on the Specify Authorization tab and in a Payor Plan Note.
 - To monitor charge limits for services including monitoring the 104 yearly Medicaid visits.
2. **For the Medicaid 104 visit count**, authorizations must be set up to accurately count each billable Medicaid visit.
 - **It is important to set up a new authorization each year for all Medicaid patients. All Medicaid authorizations expire the last day of the calendar year and must be reentered before any new charges are generated for the new calendar year.**
 - The authorization will still be in effect no matter how many times in a year that the patients transfer from Medicaid to other insurances and back again.
 - When the balance is depleted, the services will automatically roll over to the second insurance.

- If a Medicaid patient is readmitted, refer to the previous admissions that had Medicaid in the billing sequence and look at the remaining balance of the authorizations for the current year. The remaining balance will be the new authorized units for the new admission.
3. **For Medicaid patients:**
 - Prior to setting up the authorization, go to the Bill Sequence tab from Specify Coverage Information and make sure that '**CAID OVER VISIT INDIGENT**' is listed in the bill sequence.
 - If it is not listed, add it to the bill sequence by following the directions given previously in this document.
 4. Go to **the Specify Prior Authorization** icon in Customer Maintenance, after selecting the Customer and Admission.
 5. **Ensure the applicable plan is highlighted** prior to entering the authorization. By the default the first plan is highlighted and this may not be the correct plan.
 6. Click on the **New** icon. The **Specify New Authorization** screen appears.
 7. Enter the **Authorization Number** as received from the payor.
 - For Medicaid, enter your 2-digit county number then a 2-digit code of your choice (ex. 5123). You do not need to keep a log nor keep track of this number.
 8. **Begin Date:** Use the drop down calendar to select the authorization effective date.
 - If the authorization is effective immediately, leave current date in the field.
 - For Medicaid, enter the beginning of the year, for existing admissions, or the start of care date for new patients.
 9. **End Date:** Use the drop down calendar to enter the last date that the authorization is in effect. If the authorization is not for a specific date range, leave this field blank.
 - For Medicaid, the end date is the last day of the current year.
 10. **Authorized Units:** If the authorization is for a maximum number of service units (visits, hours or supplies), enter the maximum number in the field.
 - For Medicaid at the beginning of the calendar year, enter 104 signifying 104 visits.
 - If this is a Medicaid readmit, refer back to previous admissions to determine the balance of the authorized units. This amount will be the authorized units for this admission instead of 104 units.
 11. **Authorized Dollars:** If the authorization is for a maximum dollar amount, enter the amount here.
 - For Medicaid, leave this field blank.

12. **Supplies Included in Authorization:** Select this checkbox if the authorization automatically includes the necessary medical supplies.
 - For Medicaid, do not check this box.
13. If a separate **authorization** is needed for supplies, leave the **Supplies Included In Authorization** box blank.
14. Click **OK** to return to the **Specify Prior Authorizations** tab.
15. Use the following instructions as needed to indicate specific discipline authorizations. Most private insurance company issue authorizations by discipline.
 - You will not need to set up discipline specific authorizations for Medicaid.
16. Click on the **Service Detail** tab.
17. Click on the **New** icon.
18. The **Specify New Detailed Authorization** window appears. Enter the information in the following fields:
 - **Service Type:** Click on the **binoculars** to select the Service authorized (SN, PT, OT, ST, HHA, MS, RD)
 - **Service:** Leave **blank** unless otherwise directed by Supervisor.
 - **Authorized Units:** Enter the number of visits for the service authorized.
 - **Authorized Dollars:** Leave blank unless otherwise directed by Supervisor.
 - Click **OK**.
19. Repeat steps to enter the authorization for each service for the customer.