

## INSURANCE PROGRAMS

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Wanting to bill insurance with your program? Do you know what you need to do to be compliant? This article talks in brief about compliance surrounding insurance programs you are associated with as a provider.

First, for •profit and non •profit agencies can be on provider panels. So lets ask an obvious question: do you want to accept insurance for service? This is a very individual decision. It may be based on your mission and whom you want to serve or it may come down to a regional or state preference. For example, we are a Medicaid provider. However, in other states it can be more difficult to be granted "preferred provider" status. In the end you need to decide what works for your business.

When you apply to be a "preferred provider" or to be on a "provider panel" with an insurance company, you will be asked, what I call "demographic questions". These questions center on the "who, what, where, and how" of your business. Some applications are set up as check boxes and are very straightforward. Others may request descriptive information of what you do. This is the number one stumbling block I hear within the field: the description of what you do. I promise I will cover that on another blog very soon.

From a compliance standpoint, the number one "offense" falls under documentation. You must document thoroughly.

- Signature deficiencies: therapist(s), client/patient or guardian
- Forgetting to sign a therapy note
- Forgetting to date a therapy note (including documentation of time of encounter)
- A signature that is not legible (it has to be legible to anyone)
- Failure to document thoroughly and clearly "follow up" care
- Incomplete intakes, plans or notes
- Failure to properly document diagnosis (Axis I •V)
- Failure to document cancellations and no shows
- Incomplete or vague entry and exit documentation (notes are not clearly explaining why the client is there, and exit/discharge documentation not clearly identifying whether goals and objectives were met)
- Failure of documentation to be consistent from client to client (writing notes one way for private pay, one way for grants, one way for insurance) This is a big red flag for auditors!
- The general use of NOS (Not Otherwise Specified) with a diagnosis beyond 30 days
- The use of R/O (Rule Out) beyond 30 days (after 30 days you should have a good idea what the diagnosis is)
- Disorganized filing cabinet
- Incomplete discharge summaries (the kiss of death in a mental health audit)
- Not having charts completed within a "reasonable" time frame (HSOTC policy: 24 hours to write a note and 7 days to close a chart out after discharge)

So do you want to pursue insurance? Hold on to that answer...there is a catch here. As you recall from blog number one, all sorts of agencies have a vested interest in you from a compliance standpoint. It doesn't matter whether you accept insurance or not, the above errors are not acceptable to any agency auditing you in reference to you providing mental health services (a worker's comp audit won't include client charts).