

Policy: It is the policy of the Division of Mental Health and Developmental Services to establish and collect fees for services rendered to consumers and to have uniform billing procedures and practices across all mental health agencies.

Purpose: The purpose of this policy is to comprehensively outline the standards and methods that the Division's Centralized Billing Office and the mental health agencies' fiscal intake staff members will use to document the services provided to consumers and how these will be claimed and billed, as well as how revenue will be received and processed.

Procedure(s):

I Principles and Guidelines:

- A. It is the mission of the mental health agencies of MHDS to serve the mental and behavioral health needs of the individuals of the communities in the state of Nevada. Agencies and clinics of MHDS are united in providing care based on the following principles:
1. Treat all patients equitably, with respect, dignity, confidentiality, and with compassion;
 2. Serve the emergency mental health care needs of everyone in the community, regardless of the consumer's ability to pay for care;
 3. Assist consumers who cannot pay for all or a portion of the care they receive; and
 4. Financial services and assistance provided by the agency is not a substitute for personal responsibility. All consumers should be expected to contribute to the cost for their care, based upon their ability to pay.
- B. The following guidelines show how agencies can better serve their consumers. The agencies of MHDS must strive to ensure that they are meeting these guidelines as they work each day to find the most effective methods to best meet their consumers' needs.
1. Communications:
 - a) Agencies and their billing staff should clearly communicate agency policies to consumers about the bills they receive for care and services, expectations for payment, and options available;
 - b) Agencies should respond promptly to consumers' questions about their bills and to requests for financial assistance;
 - c) Agencies should use a billing process that is clear, concise, correct, and consumer-friendly; and

- d) Agencies should make available for review by the public specific information in a meaningful format about what they charge for services.
2. Qualification for Coverage:
- a) Agencies should provide consumers, both potential and current, with information on sliding fee-scale policies and other known programs of financial assistance or other forms of public assistance programs available from state/county/local governmental entities;
 - b) Agencies should communicate this information to consumers in a way that is easy to understand, culturally appropriate and in the most prevalent languages used in their communities; and
 - c) Agencies should share these policies with appropriate state and municipal health/human services agencies, and other organizations that assist people in need.
3. Application of Policies:
- a) Agencies must ensure that all written policies are applied consistently for assisting low-income consumers;
 - b) Agencies must ensure that staff members who work closely with consumers (including those working in consumer registration and admissions, financial services, billings and collections as well as nurses, physicians, clinicians, social workers and others) are educated about agency billing, financial assistance and collections policies and practices.
4. Care to Consumers with Limited Means:
- a) The Division's agencies should review, at a minimum annually, all current charges and ensure that the charges for services and procedures are reasonably related to both the cost of the service and to meeting the community's mental health care needs;
 - b) The Division and agencies should have policies to offer a sliding fee scale to consumers who, after participating in a financial interview with agency staff, are determined to be eligible under the agency's criteria for such reductions. Policies should clearly state the eligibility criteria, amount(s) of reductions, and payment plan options.
5. Ensuring Fair Billing and Collection Practices:
- a) Agencies must ensure that consumer accounts are pursued fairly and consistently, reflecting the public's high expectations of MHDS and its delivery of mental and behavioral health services;
 - b) Agency policies regarding referral of consumer bills to outside collection agencies must be in accordance with state law, administrative regulations and Division policy, and follow established procedures;

- c) The agency's financial services and assistance policies must clearly state the eligibility criteria (i.e. income, assets, employment, etc.) and the process used by the agency to determine when a consumer is eligible for inclusion on the sliding fee scale. Such process should take into account where and how far a particular consumer falls relative to the Federal Poverty Guidelines as published by the U.S. Department of Health and Human Services (updated annually);
- d) Agencies must implement written policies concerning when consumer debt is advanced for collection. These policies must also be in accordance with state law, administrative regulations and Division policies, and follow established procedures.

II. General Requirements:

A. Fees for Services:

Each mental health agency shall establish and collect fees for the following services, as defined by the capabilities of the agency:

- Emergency Services;
- Inpatient Psychiatric Hospital Services;
- Medication Clinic;
- Outpatient Mental Health Services;
- Program for Assertive Community Treatment (PACT);
- Psychosocial Rehabilitation;
- Rehabilitative Services;
- Residential Support Services; and,
- Service Coordination.

B. Consumers with Medicaid/Medicare:

Consumers with Medicaid or any combination of Medicaid and another payer will be considered as having provided payment in full. Consumers with Medicare and supplemental insurance will be responsible for full payment of all applicable co-insurance, co-payments, and deductibles unless the sliding fee scale has been applied based on the consumer's ability to pay.

C. Consumers without Medicaid:

These consumers will be assessed for ability to pay using a sliding fee scale. Consumers unable to pay the full amount will be charged based on a sliding fee schedule, which allows a consumer to pay a portion of the actual cost. Payments made in accordance with the fee schedule will be considered payments in full.

- D. Third-party:
All third-party payers, such as commercial insurance companies, are billed at the agency's full cost of services that is established on a regular basis through a cost allocation agreement and analysis.

- E. Uniform Billing Procedures:
 - 1. These procedures and methods shall be consistent with the practice management/billing software system and its adjuncts which are currently being utilized by the agencies. All division and agency billing staff shall follow the same general workflow process for documentation, preparation of and transmission of claims.
 - 2. The Division's Administrative Services Officers (ASO's), Billing Liaisons, and Centralized Billing Office management and supervisory staff will meet at least quarterly to complete an ongoing analysis of the billing system and procedures. The purpose of these meetings will be to discuss current billing issues to ensure the Division is making its best effort to maximize all non-general fund revenues.
 - 3. Each Division agency will review, update, and/or institute procedures to ensure that individuals who have mental health benefits and are seeking services are educated and consulted about their care options and provider choices at the time of their initial treatment planning and treatment reviews.

III. Financial Eligibility - Process and Documentation:

- A. Overview:
No services will be denied consumers because of inability to pay. For those consumers who claim inability to pay full cost of care, it is Division policy that the burden of proof to demonstrate inability to pay is the responsibility of the consumer or responsible parties. A tentative fee may be estimated at the first visit based on oral input for purposes of collecting payment. Consumers are to be assessed a fee based upon an investigation of the consumer's ability to pay. The investigation will consist of a face-to-face interview of the consumer and the receipt of documentation to corroborate the results of the interview. The procedures contained herein define what an acceptable investigation is. It is recognized that documentation may be difficult to obtain in a great number of investigations. It is also recognized that it is the Division's experience that most of our consumers are seriously mentally ill and have very limited resources.

1. The chart below illustrates the general process the agencies should be using when collecting or following up on financial eligibility information from consumers requesting services.

Contact with Consumer	Action
Initial Request for Services/Intake	<ul style="list-style-type: none"> • Verify eligibility for services- meet with financial or billing staff for interview to gather necessary demographic and financial information and documentation. • If the consumer does not have the necessary documentation at intake, they will be asked to bring it at their first scheduled appointment. • Consumer will be advised at the outset of services that they will be financially responsible for the cost of treatment. All payers will have access to a sliding fee scale which will be posted in a conspicuous location at the agency. • Pending receipt of documentation, consumer will be tentatively entered into system at 100% full fee Self Pay.
Subsequent Appointment(s) For Treatment Services	<ul style="list-style-type: none"> • Following initial intake, each time the consumer arrives for services when their financial information is lacking, they will be directed to see the financial or billing staff for follow up.
Receipt of Documentation	<ul style="list-style-type: none"> • Once documentation has been received and logged in the system, consumer will be billed accordingly and will be responsible for payment according to the terms of their eligibility. Information and changes in consumer financial resources status will be reviewed and updated as changes occur, or at a minimum on a yearly basis.
Continued Lack of Documentation	<ul style="list-style-type: none"> • Financial intake staff will review consumers lacking necessary financial or demographic documentation at each appointment for services.. In circumstances where information is not received, the consumer may see a temporary delay in delivery of services, or may be billed at 100% of the full cost of services, until the consumer meets with agency financial intake staff to determine their true status.

2. The Division will assess fees at the outset of treatment services based upon the results of the initial interview. This assessment will remain in force for the consumer for a period of one (1) year from the first date of service; on an annual basis, financial intake staff will review and revise a consumer's financial and demographic information to determine if their payment status remains the same or if adjustments are warranted (based on such factors as income increase/decrease, household changes, job status, etc.) A follow-up to the initial interview will be made at each appointment for service to check the status of required documentation if this was lacking. A fee of less than full cost without adequate documentation must be approved in writing by the agency ASO and financial intake manager. The rationale for the assessment of the fee shall be fully documented in the consumer's file. In cases where the fee prescribed by this policy is considered unreasonable by both the consumer and agency financial intake office, an appeal for variance or adjustment may be made to the agency ASO/business office manager. Examples of such cases would be:
 - a) Family member with limited income and resources faced with tremendous medical bills for a family member with a terminal illness;
 - b) Family faced with great financial loss due to a business failure;
 - c) Family suffering great real and personal property loss due to a disaster and not covered by insurance;
 - d) Situation in which normal billing and collection efforts would be deemed potentially harmful to the consumer or consumer's treatment as determined by the consumer's clinician, in consultation with the agency director; and,
 - e) General extenuating circumstances determined on a case-by-case basis.
3. In addition to providing consumers with emergency care, consumers insured by private health insurance plans may be eligible to receive agency services. Consumers insured by these plans (e.g., HMOs, PPOs, culinary union, etc...) are required to seek services first from their private health plans before requesting care from the mental health agencies; in the instances where such services are not available to the potential consumer through their plan, they can be considered eligible for agency-delivered services. Consumers insured by private health plans for mental health services (ideally those with which MHDS has a provider agreement, but staff will also bill those plans without a provider agreement in place) may receive treatment from state mental health agencies. Agency financial intake staff should contact a consumer's private health plan representative at the start of verification of eligibility and ask: "Where would you like us to send your consumer for services?"

before providing agency services. As part of the eligibility process, staff should determine that consumers can demonstrate if their insurance benefits for mental health or related prescription services have been exhausted. In the instances where it can be proven the consumer's private health plan benefits have been exhausted for a limited time (such as until the end of the calendar or policy year), the consumer can receive agency services until the private health plan benefits are reinstated.

4. Each agency shall designate one staff position to be accountable for ensuring the implementation of these policies and procedures. In most cases, that will be the agency financial intake manager.

B. Documentation of the Financial Intake:

To determine a final fee assessment at, or for less than, full cost that can be definitively authorized, verified evidence shall be required of current income and resources pertaining to dates of service. A paycheck stub, ideally going back 2-3 consecutive pay periods, is the preferred documentation. The following are acceptable supplemental documentation:

1. *To Verify Level of Income - Current paycheck stub(s) (ideal) ,or any combination of the following:*
 - a) A copy of the most recent year's Federal Tax Return filed by the consumer or responsible party; OR
 - b) A statement from the consumer's employer or source of income, signed and dated; OR
 - c) A statement from a governmental agency that provides the consumer's income; OR
 - d) A copy of the most recent government check or determination letter; OR
 - e) A copy of a recent Bank Statement (to verify paycheck deposits, other income deposits, etc.).
2. *To Prove Lack of Income and/or unemployment:*
 - a) A copy of a termination notice from the most recent employer; OR
 - b) A copy of the final paycheck stub from the last employer (must indicate "Final"); OR
 - c) A copy of registration with the unemployment office or notice of pending claim; OR
 - d) A copy of notice of claim pending with the welfare department; OR
 - e) A claim determination or pending notice for disability or SSI; OR
 - f) Homeless shelter I.D. card; OR
 - g) Valid Nevada Medicaid card or verification of current enrollment; OR
 - h) Nevada Food Stamp I.D. card; OR

- i) Proof of enrollment in Salvation Army or other valid rehabilitation program; OR
- j) Residential group home or SLA participation and status; OR
- k) Approval letter from city or county agency approving consumer for indigent benefits; OR
- l) If none of the above can be obtained, we will accept a statement written and signed by the person providing the consumer's support attesting to the consumer's lack of employment. This statement must include the provider's name, address, and phone number so that the information can be verified (see sample "Statement of Support" form attached).

IV. Documentation of Diagnosis and Associated Conditions:

- A. Since entry of accurate diagnosis information is a key component of effective billing, each agency shall have clearly defined roles and responsibilities in the billing workflow process that designate who among staff is consistently responsible for monitoring the inclusion of consumer diagnosis in the practice management system as consumer bills are being prepared.
- B. Each agency shall develop procedures for coordinating with the clinical and practitioner staff to ensure that correct diagnoses are being recorded for billing purposes. In the instances where lack of diagnosis information becomes an impediment to effective billing, the billing supervisor shall consult with the agency director and medical director to identify problems and propose solutions.

V. Coding For Services:

All mental health agency service codes entered by staff must properly and accurately reflect the procedure that was rendered to the consumer. Service codes must be cross-walked to the most current CPT (Current Procedural Terminology) and/or HCPCS (Healthcare Common Procedure Coding System) codes, which are updated on a yearly basis. These codes must reflect the payment authorization guidelines as determined by First Health Services Corporation (FHSC) and the Division of Health Care Financing and Policy (DHCFP), and should be reimbursable, linked to tracking functions, or identified for other agency purposes. Guidelines for coding for services among the agencies will involve:

- A. Each agency shall designate and provide training to a billing or other staff member who will be responsible for reviewing and suggesting changes in the service codes directory.

- B. The Division will maintain a current CPT, ICD-9 (International Classification of Diseases, Ninth Revision, Clinical Modification) and HCPCS coding library.
 - C. The Division and agencies will be Health Insurance Portability and Accountability Act (HIPAA) compliant in its coding.
 - D. These codes shall be reviewed for updates, accuracy, and potential for reimbursement on an annual basis by a committee composed of the Centralized Billing Office Manager and each mental health agency's Billing Liaison in direct consultation with the Statewide Medical Director, or designee.
 - E. The Statewide Medical Director, or designee, will ensure that the work performance standards of each physician or psychiatrist require full documentation in the consumer and billing records of all services provided. All services provided will be assigned the appropriate billing code by the physician or psychiatrist.
 - F. The Statewide Medical Director. Or designee, will review the level of compliance with these guidelines at least annually for the performance evaluation of each physician or psychiatrist,.
 - G. Staff responsible for revising the code structure should use standard coding manuals/materials as published by the American Medical Association and published guidelines from FHSC and DHCFP.
 - H. The results of the review will be made available to the agency director, business manager, and the Division Chief ASO.
- VI. Follow-up Collection of Consumer Information:
- Consumer personal, diagnosis, financial, and demographic information should be updated or verified by agency billing or other designated staff; every consumer appointment should be reviewed to determine if all necessary information has been collected sufficient for billing purposes. This information should then be entered into the practice management system in order to ensure up-to-date recordkeeping and accurate consumer data so bills can be processed with all necessary information.
- VII. General Revenue Cycle Workflow Process:
- Mental health agencies will need to have a workflow process organized and operating that includes several basic components that will ensure effective and timely billing and collection processes to be completed by the Division

Centralized Billing Office. The following guidelines shall be common to all agencies in the structure and execution of billing/collections activities:

- A. **Timely Billing:**
Consumers receiving services from mental health agencies will be billed monthly by the 25th of the following month of services being rendered. All open accounts will be reviewed with an aging report that lists accounts in payable status over a 60-90-120 day period to identify those accounts that are not receiving payment. These claims shall be given priority in collections.
- B. **Completion of Charges in the System:**
On a no less than monthly basis, the agency billing liaison, or other designated staff, will evaluate that the consumer information in the system is accurate and contains all proper charges and is ready for claim processing and billing.
- C. **Error Review and Correction:**
Prior to claim transmission, all consumer bills shall be reviewed by Central Billing Office staff for potential errors that would result in claim rejection or denial. These errors will be compiled and forwarded to the applicable agency billing liaison or other designated staff for correction and reset in the system. The agency billing liaison, or other designated staff, shall follow up and determine if the necessary changes have been made; if it is determined that errors are not being fixed in the practice management system and are impeding billing activities, a listing of uncompleted error corrections shall be compiled and brought to the attention of the agency director, business manager, and the Division Chief ASO for corrective action.
- D. **Creation of Billing Batches:**
All claims that are being prepared for billing in a regularly scheduled billing cycle shall be grouped together in batches based on the billing agency's applicable criteria (type of service, date of service, location, etc...). These batch claims will form the basis of transmission to the payer for identification and payment.
- E. **Closing Charges:**
Subsequent to any error correction and review, all claim charges for that billing cycle will be closed and the batch(s) prepared for transmission.
- F. **Transmission of Bills:**
Once charges have been closed and claim batches reviewed and prepared, they will be transmitted on a monthly basis no more than 25 days after the end of the calendar month. Either paper or electronic claim batches will be transmitted to the appropriate payer for adjudication, but it

will be Division policy that all claims will be sent electronically, if possible, to facilitate cash flow and quicker processing time.

- G. Open Claims:
All open accounts will be reviewed every three months to identify those accounts that are not receiving payments. These will be reviewed on a consumer-by-consumer basis and given priority by billing staff in working for payment or moving to write-off status, in accordance with Division and agency policies.
- H. Track and Log Claims Sent:
All claims and batches sent will be noted and logged by billing staff to provide an informal record of billing activity and a back up to demonstrate claims worked and transmitted to payers for adjudication.
- I. Receipt of Payments:
All payments for services are to be received at the agency or rural mental health clinic where the consumers services had most recently been rendered. All payments for services claimed will be tracked and recorded in the practice management system and matched to the appropriate service.
- J. Posting Payments:
Copies of all payment information (i.e. copies of checks, paper remittance advices, explanation of benefits, etc) will be transmitted to the Centralized Billing Office no later than 10 working days after the agency/rural mental health clinic has received such payment in a HIPAA compliant manner. All payments received will be posted to the system within 1 - 3 days from the date they are received in the Centralized Billing Office by Centralized Billing Office staff.
- K. Review of Denials:
Claims that are denied for payment will be reviewed by the Centralized Billing Office staff to determine errors and their potential correction. Those claims that can be fixed will be corrected and resubmitted during the next billing cycle. Those claims where denial status is uncertain will be appealed to the payer; upon further rejection, Centralized Billing Office staff will forward the claim information to the agency billing liaison who will coordinate with the agency ASO for a decision on adjustment or write-off. All claims to be written-off or adjusted will be done in accordance with state, Division and agency policies

VIII. Consumer Direct Payment for Services:

Mental health agencies will collect consumer fees for treatment services, and have procedures in place to follow-up on collections for payments for these

services, as well as handle any delinquent and bad debt accounts that occur. Agencies shall establish a fee schedule for services rendered and, through a process of interview and financial investigation, determine the ability of the consumer to pay all or any part of the cost for services rendered based upon the following criteria:

A. Sliding Fee Scale:

The sliding fee schedule (see NRS 433A.590 [3]) is to be used only if a determination is made that the liable party cannot pay the full amount. If it is determined that a consumer or responsible party is unable to pay for the full cost of treatment, the current Division-wide fee schedule shall be used.

1. Basis of sliding fee scale are the federal poverty guidelines determined by the US Dept. of Health and Human Services; these are published each January/February or when issued. The sliding fee scale will be updated yearly by the Division subsequent to the publishing of the most recent federal poverty guidelines, and distributed to MHDS agencies.
2. The sliding fee scale will be used to assess consumer ability to pay for services.
3. The sliding fee scale will be used by financial services or billing staff during the front-end of the revenue cycle or financial eligibility interview process to determine if a consumer is capable of paying at an appropriate level for services requested, or if the consumer meets the applicable agency criteria and should be classified as "Indigent" and a recipient of "Donated Services."

B. Billing for Consumer Self-Pay Claims:

1. To be used in conjunction with sliding fee scale charges;
2. The consumer or responsible person must be apprised and counseled regarding the charges that will be assessed to them based on their ability to pay, and it will be communicated to them in clear terms that they will be expected to share in the costs for their treatment;
3. Notice will be posted in a conspicuous manner at each agency, where financial interviews are conducted, about the consumer's responsibility for payment for treatment services received;
4. If a consumer meets the criteria for the zero level on the sliding fee scale established by the agency, the burden of proof will be on the consumer to provide the documentation. Generally, the consumer will be documented in the practice management system by setting up a direct consumer guarantor with a zero (0) percent guarantor plan; the consumer must also have a "Donated Services" guarantor linked with a "Non-Recoverable" plan. Charges for services then fall into the "Donated Services" guarantor area. This will be done in order to avoid over-inflation of consumer charges;
5. Consumers meeting the criteria for sliding fee scale levels above

zero (0) owing a balance after the payment of a third-party payer (i.e. co-insurance, deductible, or co-payment), shall have that balance adjusted based on the amount remaining after the payment of the third-party payer has been received and posted;

6. Consumers receiving services from mental health agencies will be billed monthly by the 25th of the following month of services being rendered; And,
7. Payment arrangements should be made in advance or upon discharge from services with the agency billing or financial services office.

C. Collection of Delinquent Bills:

Billing for services shall be in accordance with the State of Nevada's Office of the Controller Accounting Policies and Procedures, pp. 24 - 28 with a minimum billing amount of \$10.00 being established. Billing will be accomplished as follows:

1. Inpatient care is billed at least monthly and/or at time of discharge;
2. Outpatient services will normally be paid at the time of each session or billed at least monthly;
3. If payment is not received, follow-up billings 30, 60, and 90 days after the first bill will be sent and/or collection notices will be sent every 30 days until the debt is collected or deemed uncollectible and written off (at least three [3] agency collection efforts will be made);
4. A payment schedule for service(s) received may be negotiated on an individual case basis for payment on outstanding balances. The agency business manager, in conjunction with the agency billing liaison, shall review and approve each payment schedule. Whenever adjustments to a payment schedule are sought on the basis of excess expenses to income, documentation of those expenses should be provided to agency billing or financial staff during initial and any subsequent financial interviews; and,
5. NRS 433A.610 references a review of the "estate" in determining ability to pay. That would obviously include assets. As such, ideally all assets available should be taken into consideration in determining consumers' ability to pay. This would result in billing full cost to parties having substantial assets, subject to the limitations established by NRS 433A.620. For a consumer supplemented by the state, for example, a consumer in a Supported Living Arrangement (SLA), income would be considered zero for purposes of assessing a fee. For consumers who fail to pay after repeated collection efforts, where evidence indicates that assets exist to pay for services rendered, it shall be at the discretion of the agency director in consultation with the agency ASO, on a case-by-case basis, whether to conduct a full asset test on a particular consumer or consumers in order to determine their ability to pay for services.

Each agency, in consultation with Division fiscal management, shall adopt uniform guidelines that govern the frequency, method and personnel assigned for such asset tests and investigations.

D. Collections Procedures:

The procedures for the collection of fees shall be in accordance with the State of Nevada's Office of the Controller Accounting Policies and Procedures and contain the following:

1. Keep a record for each consumer showing date of visit, charges and payments;
2. Keep a journal or receipts for daily posting of payments;
3. Use a practice management scheduling mechanism (i.e. Avatar) accessible to the business office to record all consumer visits;
4. In the instances of cash collection at the agency site, issue a pre-numbered receipt to each consumer at the time of payment in person;
5. Those agencies that do not have a system that records monies due for each visit must ensure reconciliation or visits shown in the central appointment book or scheduling system with the individual consumer accounts and receipts journal at least monthly;
6. Receipts should be deposited no less than weekly and intact to the account of the treasurer of the state of Nevada or a local bank approved for the deposit of state funds. Under no circumstances should collections remain undeposited for more than five (5) working days, as per NRS 353.250. Collections not deposited the day received must be kept in a safekeeping device that is adequate to safeguard cash; and,
7. Internal controls, consistent with state policy and standard accounting procedures, shall be developed and implemented within the agency billing office to reduce the potential for errors or misappropriation. These controls shall be submitted for approval by the agency business manager/ASO and Division Chief Administrative Services Officer (Chief ASO).

E. Refusal to Pay - Required Action:

1. Services shall not be discontinued if a consumer refuses to pay the assigned fees or refuses to provide needed financial information, including insurance coverage to seek third-party payments. However, the agency business manager and the agency billing liaison are to be promptly notified, and collection actions shall be taken as soon as possible;
2. It shall be at the discretion of the ASO/business manager to make the determination to delay the continued delivery of services to consumers who refuse to pay until they present themselves to the financial or billing staff to make payment arrangements or provide

documentation to confirm a change to their financial status and their inability to pay for their treatment services; and,

3. Based upon reports generated by Centralized Billing Office staff on a quarterly basis that show consumers with balances outstanding longer than 180 days without some form of payment and illustrative of their refusal to pay, a letter will be sent to the consumers' addresses on file informing them that any future services may be held pending contacting the billing office to make payment arrangements or adjust their financial status.

F. Demand Letters and Referrals to Deputy Attorney General:

1. If no response is received for bills of \$500 or more within 30 days after the third billing, the consumer shall be notified that continued delinquency may result in action by the state's attorney general.
2. If no response is received within 30 days after consumer notification, bills totaling \$500 or more will be referred to the deputy attorney general requesting the issuance of a demand letter. Information to be contained in the Deputy Attorney General demand letters include:
 - Name of agency providing the service;
 - Name of consumer;
 - Address of consumer or third-party payer; and,
 - Amount due.
3. The deputy attorney general will take no further action on bills unless by request of the agency director and business manager. If no response is received within 30 days of the deputy attorney general demand letter, the agency billing liaison and/or financial services manager will jointly review the income, assets and pertinent data involving the account. If deemed uncollectible, a request for the Board of Examiners to designate the debt as bad debt will be made. A listing of accounts deemed uncollectible will be prepared quarterly and submitted to the Centralized Billing Office manager. The submission of the list to the Board of Examiners must be pre-approved by the agency director and the Chief ASO. Approval should be granted only if sufficient and reasonable collection efforts, as required by SAM, NRS, and this policy are clearly documented in the agency records. If the account is deemed to be potentially collectible, where evidence exists of assets or income that may be sufficient to satisfy the debt, collection efforts will continue until the debt is collected.

IX. Indigent Consumers:

- A. An indigent consumer will be defined by the Division's mental health agencies as those persons requesting mental health services who meet

the criteria set forth by the agency in conjunction with the sliding fee scale and who fall in the “zero” category on the sliding fee scale.

- B. Eligibility for inclusion in indigent status must be confirmed by the financial services or billing staff of the agencies; proper documentation must be collected that verifies the consumer does not possess sufficient resources to pay for the costs of treatment.
 - C. Determination of indigent status must be obtained as quickly as possible in the financial interview process. If it is determined at the beginning of delivery of services that the consumer qualifies for inclusion at the “zero” end of the sliding fee scale, their services should be immediately classified as “Non-Recoverable,” and a payment code should be assigned to the consumer that denotes them as indigent and that payment should not be expected for the services rendered.
- X. Write-Offs:
- A. The mental health agencies should develop and/or have in place a clearly defined process for write-off’s for uncollectible bills for services rendered to consumers, in accordance with NRS and administrative regulations. There will be two (2) general classifications of write-offs within the system, based upon the amount of the balance:
 - 1. Generally, accounts with balances in the range of \$1 - \$499, aged 120 days or older, will be examined by the agency billing liaison in conjunction with the agency ASO. The billing supervisor may adjust these claims internally to “Non-Recoverable” without submitting these claims to a formal collection process. Staff will generate a report listing these amounts, the consumers to whom they pertain, and the days outstanding. These amounts will then be submitted for write-off by the agency on a quarterly basis to the Controller’s office in accordance with the procedures established. A report on the write-off amounts will be provided to the Centralized Billing Office Manager and Chief ASO, and agency director.
 - 2. Accounts with balances in excess of \$500, aged 120 days or older, should be referred to the agency business manager/ASO, and the Centralized Billing Office Manager notified for further collection if a determination has been made that the charges assessed were appropriate and properly established.
 - 3. If, after agency demand and AG demand letters have been sent with no payment/response, the agency billing liaison may deem these claims unrecoverable. The Centralized Billing Office will be notified of such and will adjust these claims to “Non-Recoverable”, generate a report listing these amounts, the consumers to whom they pertain, and the total days outstanding. These amounts will then be submitted for write-off by the agency on a quarterly basis to

the Controller's office in accordance with the procedures established. A report on the write off amounts will be provided to the Centralized Billing Office Manager and Chief ASO, and agency director.

4. If it is determined during an account review that the charges were inappropriate, the agency billing liaison will notify the Centralized Billing Office to adjust rather than write off these charges.

B. Bad Debt:

1. General Criteria for Allowable Bad Debt:

- a) The debt must be related to covered services and derived from deductible and co-insurance amounts;
- b) The provider/agency must be able to establish that reasonable collection efforts were made;
- c) The debt was actually uncollectible when claimed as worthless; and,
- d) Sound business judgment established that there was no likelihood of recovery at any time in the future.

2.. Reasonable Collection Effort:

To be considered a reasonable collection effort, an agency's effort to collect monies owed to it should be consistent among all types of consumer financial classes (e.g. Medicaid, Medicare, self-pay, commercial). It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the consumer's personal financial obligations. It also includes other actions which may include subsequent billings, collection letters, telephone calls, or personal contact with the party, which constitute a genuine rather than a token collection effort.

3. Documentation Required:

The provider's/agency's collection effort should be documented in the consumer's file by the copies of the bill(s), follow up letters, reports of telephone and personal contact, etc.

4. Other:

- a) In general, before going on a bad debt log, accounts must have been worked in-house for at least 120 days (or three [3] agency collection efforts) after Medicare's determination of the consumer's portion and the hospital's initial billing;
- b) Division fiscal management, in consultation with agency billing staff, shall develop a reporting and tracking report for services (and their attributable charges) delivered to indigent consumers. These "Non-Recoverable" amounts shall be cataloged for inclusion on an agency's bad debt report. This report shall be uniformly developed and implemented across all mental health agencies;
- c) Documentation should be maintained that the collection

- agency/deputy AG has terminated efforts to collect a bad debt account and returned it as uncollectible; and,
- d) Bad debts must be included on the agency's Medicare Cost Report for all appropriate consumers who qualify, and be reviewed on a regular basis for processing.

XI. Rehabilitative Services Billing:

Please reference Policy #3.005, Medicaid Mental Health Rehabilitative Services Billing and Charting/Documentation Requirements, for a full description of the general information and process of billing for Rehabilitative Services.

XII. Reports and Reporting Requirements:

- A. The Centralized Billing Office will need to maintain accurate reports on the activities and results of the billing cycle and submit these reports to each agency's billing liaison and ASO, and the Chief ASO IV on an on-going basis. Reporting for the Division agencies shall be standardized in order to provide historical context for billing performance, identify revenue cycle problems in a timely manner, and target areas for improvement or correction.
 - 1. Expectations for billing performance will be formulated by Division management, in accordance with general medical billing industry measurements. These expectations will be developed in consultation with the Centralized Billing Office manager, each agency's billing liaison, and communicated to Centralized Billing Office Staff and agency billing staff on a regular basis and updated as circumstances warrant.
 - 2. Some of the main factors that reporting will seek to establish will be:
 - a) Timely and regular submission of billing claims;
 - b) Collection of 100% of all Medicaid/Medicare reimbursable services;
 - c) Collection rates for other major financial classes;
 - d) Examination of denials experienced;
 - e) Open Claims;
 - f) Days receivable outstanding;
 - g) Aging balance;
 - h) Clinician/Practitioner productivity; and,
 - i) Tracking services rendered to consumers and whether they can be reimbursed.
- B. Monthly billing reports will be submitted by the Centralized Billing Manager to each agency's billing liaison and ASO in a standard format.
- C. These reports will identify activity in several key areas, such as: services rendered, amounts claimed, aging balances, and payment totals.

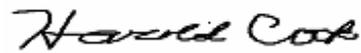
- D. Each billing report submitted will be for the month previous (i.e., the report received at the end of July will summarize activity for the month of June).
- E. Reports will be used to track and monitor billing performance on a regular basis. Results will be discussed with each agency's billing liaison and the Centralized Billing Office manager in at least quarterly meetings in order to identify trends and noticeable patterns in the revenue cycle.
- F. Summaries of the reports will also be distributed to the Chief ASO, Division Administrator, and agency directors.

XIII. Annual Performance Reviews by Division:

In addition to the reporting requirements, the Division Central Office will regularly conduct annual performance reviews of the billing activities of the mental health agencies.

- A. At the conclusion of each fiscal year (FY), one month after all charges for the end of the year have been claimed and posted, reports will be submitted to the Centralized Billing Office manager to assess the yearly performance of the agency's billing operations.
- B. Not more than three (3) months after the end of the FY, the Centralized Billing Office manager shall meet respectively with the agency billing liaison from each agency to go over results and apply performance metrics, analyze payment rates and denials, review collection issues, billing system performance concerns, and other related topics to gauge the effectiveness of the revenue cycle operations.
- C. Suggestions for improvements, problem resolution, and/or corrective action will be put in writing and distributed to the agency billing liaison, business manager, and director as well as Division management.
- D. Results will be compared over a year-by-year basis to determine trends in payment, problems encountered, and all other necessary measurements to ensure that the agency's revenue cycle is operating within accepted industry standards.
- E. The results of the annual performance review will be summarized and transmitted to the Division Administrator and Chief ASO.

- XIV. Each agency shall formulate policies and procedures to implement the provisions in this policy or shall incorporate this policy into its policy and procedure manual.



Administrator

ATTACHMENTS:

- A. NRS Provisions Governing Billing/Collections
- B. Statement of Support

Effective Date: 9/30/01

Date Revised: 11/05/07, 3/18/10

Date Reviewed:

Date Approved by MHDS Commission: 5/18/01, 3/18/10

ATTACHMENT A Nevada Revised Statutes (NRS) Provisions Governing Billing/Collections

NRS 433.404 Schedule of fees for services rendered through programs supported by State; disposition of receipts; amount of fee for services of facility.

1. The Division shall establish a fee schedule for services rendered through any program supported by the State pursuant to the provisions of [chapters 433 to 436](#), inclusive, of NRS. The schedule must be submitted to the Commission and the Director of the Department for joint approval before enforcement. The fees collected by facilities operated by the Division pursuant to this schedule must be deposited in the State Treasury to the credit of the State General Fund, except as otherwise provided in [NRS 433.354](#) for fees collected pursuant to contract or agreement and in [NRS 435.120](#) for fees collected for services to clients with mental retardation and related conditions.

2. For a facility providing services for the treatment of persons with mental illness or mental retardation and persons with related conditions, the fee established must approximate the cost of providing the service, but if a client is unable to pay in full the fee established pursuant to this section, the Division may collect any amount the client is able to pay. (Added to NRS by 1975, 1594; A 1985, 2265; 1993, 2716; [1999, 2593](#))

NRS 433A.580 Arrangements for payment of costs required. No person may be admitted to a private hospital or division mental health facility pursuant to the provisions of this chapter unless mutually agreeable financial arrangements relating to the costs of treatment are made between the private hospital or division facility and the client or person requesting his admission. (Added to NRS by 1975, 1614)

NRS 433A.590 Schedule of fees.

1. Fees for the cost of treatment and services rendered through any division facility must be established pursuant to the fee schedule established under [NRS 433.404](#) or [433B.250](#), as appropriate.

2. The maximum fee established by the schedule must approximate the actual cost per client for the class of client care provided.

3. The fee schedule must allow for a client to pay a portion of the actual cost if it is determined that he and his responsible relatives pursuant to [NRS 433A.610](#) are unable to pay the full amount. That determination must be made pursuant to [NRS 433A.640](#) and [433A.650](#).

4. Any reduction pursuant to subsection 3 of the amount owed must not be calculated until all of the benefits available to the client from third-party sources, other than Medicaid, have been applied to pay the actual cost for the care provided. (Added to NRS by 1975, 1614; A 1993, 1239, 2723)

NRS 433A.600 Charges to non indigent client and responsible relative; recovery by civil action; disposition of receipts.

1. A person who is admitted to a facility operated by the Division and not determined to be indigent and every responsible relative pursuant to [NRS 433A.610](#) of the person shall be charged for the cost of treatment and is liable for that cost. If after demand is made for payment the person or his responsible relative fails to pay that cost, the administrative officer may recover the amount due by civil action.

2. All sums received by the administrative officer of a facility operated by the Division pursuant to subsection 1 must be deposited in the State Treasury and may be expended by the Division for the support of that facility in accordance with the allotment, transfer, work program and budget provisions of [NRS 353.150](#) to [353.245](#), inclusive. (Added to NRS by 1975, 1615; A 1985, 2272; 1993, 1240)

NRS 433A.610 Liability of certain relatives and estate of client for payment of costs; recovery by legal action.

1. When a person is admitted to a division facility or hospital under one of the various forms of admission prescribed by law, the parent or legal guardian of a person with mental illness who is a minor or the husband or wife of a person with mental illness, if of sufficient ability, and the estate of the person with mental illness, if the estate is sufficient for the purpose, shall pay the cost of the maintenance for the person with mental illness, including treatment and surgical operations, in any hospital in which the person is hospitalized under the provisions of this chapter:

- (a) To the administrative officer if the person is admitted to a division facility; or

(b) In all other cases, to the hospital rendering the service.

2. If a person or an estate liable for the care, maintenance and support of a committed person neglects or refuses to pay the administrative officer or the hospital rendering the service, the State is entitled to recover, by appropriate legal action, all money owed to a division facility or which the State has paid to a hospital for the care of a committed person, plus interest at the rate established pursuant to [NRS 99.040](#). (Added to NRS by 1975, 1614; A 1987, 1446; 1993, 1240)

NRS 433A.620 Limitation on payment from estate of client. Payment for the care, support, maintenance and other expenses of a person admitted to a division mental health facility shall not be exacted from such person's estate if there is a likelihood of such person's recovery or release from such facility and payment will reduce his estate to such an extent that he is likely to become a burden on the community in the event of his discharge from such facility. (Added to NRS by 1975, 1615)

NRS 433A.630 Special agreement for support of client adjudicated incompetent; advance payments.

1. The administrative officers of the respective division facilities may enter into special agreements secured by properly executed bonds with the relatives, guardians or friends of clients who are adjudicated to be clients with mental incompetence for subsistence, care or other expenses of such clients. Each agreement and bond must be to the State of Nevada and any action to enforce the agreement or bond may be brought by the administrative officer.

2. Financially responsible relatives pursuant to [NRS 433A.610](#) and the guardian of the estate of a client may, from time to time, pay money to the division facility for the future personal needs of the client with mental incompetence and for his burial expenses. Money paid pursuant to this subsection must be credited to the client in the clients' personal deposit fund established pursuant to [NRS 433.539](#). (Added to NRS by 1975, 1615; A 1993, 1240)

NRS 433A.640 Parties responsible for payment of charges after court-ordered admission; investigation of ability to pay.

1. Once a court has ordered the admission of a person to a division facility, the administrative officer shall make an investigation, pursuant to the provisions of this chapter, to determine whether the person or his responsible relatives pursuant to [NRS 433A.610](#) are capable of paying for all or a portion of the costs that will be incurred during the period of admission.

2. If a person is admitted to a division facility pursuant to a court order, that person and his responsible relatives are responsible for the payment of the actual cost of the treatment and services rendered during his admission to the division facility unless the investigation reveals that the person and his relatives are not capable of paying the full amount of the costs. (Added to NRS by 1975, 1614; A 1993, 1241)

NRS 433A.650 Benefits available from third party. Determination of ability to pay pursuant to [NRS 433A.640](#) shall include investigation of whether the client has benefits due and owing to him for the cost of his treatment from third party sources, such as Medicare, Medicaid, social security, medical insurance benefits, retirement programs, annuity plans, government benefits or any other financially responsible third parties. The administrative officer of a division mental health facility may accept payment for cost of a client's treatment from the client's insurance company, Medicare or Medicaid and other similar third parties. (Added to NRS by 1975, 1614)

NRS 433A.660 Collection of fees by legal action and other methods.

1. If the client, his responsible relative pursuant to [NRS 433A.610](#), guardian or the estate neglects or refuses to pay the cost of treatment to the division facility rendering service pursuant to the fee schedule established under [NRS 433.404](#) or [433B.250](#), as appropriate, the State is entitled to recover by appropriate legal action all sums due, plus interest.

2. Before initiating such legal action, the division facility shall demonstrate efforts at collection, which may include contractual arrangements for collection through a private collection agency. (Added to NRS by 1975, 1615; A 1993, 1241, 2723)

NRS 433A.680 Payment of costs of medical services rendered by person not on staff of facility of Division.

The expense of diagnostic, medical and surgical services furnished to a client admitted to a division facility by a person not on the staff of the facility, whether rendered while the client is in a general hospital, an outpatient of a general hospital or treated outside any hospital, must be paid by the client, the guardian or relatives responsible

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pursuant to [NRS 433A.610](#) for his care. In the case of an indigent client or a client whose estate is inadequate to pay the expenses, the expenses must be charged to the county from which the admission to the division facility was made, if the client had, before admission, been a resident of that county. The expense of such diagnostic, medical and surgical services must not in any case be a charge against or paid by the State of Nevada, except when in the opinion of the administrative officer of the division mental health facility to which the client is admitted payment should be made for nonresident indigent clients and money is authorized pursuant to [NRS 433.374](#) or [433B.230](#) and the money is authorized in approved budgets. (Added to NRS by 1975, 1617; A 1993, 1241, 1972, 2724; 1995, 664)

NRS 433A.690 Claim against estate of deceased client. Claims by a division mental health facility against the estates of deceased clients may be presented to the executor or Administrator in the manner required by law, and shall be paid as preferred claims equal to claims for expenses of last illness. When a deceased person has been maintained at a division mental health facility at a rate less than the maximum usually charged, or the facility has incurred other expenses for the benefit of the person for which full payment has not been made, the estate of the person shall be liable if the estate is discovered within 5 years after the person's death.
(Added to NRS by 1975, 1617)

ATTACHMENT B

STATEMENT OF SUPPORT

Date:

To: Whom It May Concern, State of Nevada

Regarding: (Consumer's Name)

Statement:

To the best of my knowledge, the above-named individual has no income. I currently provide the individual with the following:

- Food
- Shelter
- Transportation
- Clothing
- Other (specify)

I understand that this statement in no way obligates me to continue to provide this individual with these essentials, but only verifies that I am presently doing so. This information is subject to verification.

Signature:

Printed Name:

Address:

City/State/Zip:

Telephone: (Required)

Relationship to the above-named individual: