ACCESS
Community Health & Research Center

| Policy Name: Policy Section/ Number: | Created By: | Initial Date: | Current Date: | Pages: |
|---|---|---|---|---|
| Standard Procedures for Private Insurance and Self Pay for Mental Health Evaluation and Treatment Section __/# ____ | Ana Dutcher Quality Assurance Manager | 4/1/2019 | 1/24/2022 | Page **1** of **5** |

| Approved By: Mohamad Khraizat | Title: Manager of Health Operations |
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## I. POLICY:

ACCESS CHRC will provide behavioral health services for private insurance and self-pay/out of pocket clients with the financial responsibility left to the client. Although we accept insurance, the client is still responsible for the payment of the services if insurance denies the claim. Client will be responsible to co-pays and deductibles which are due upfront before the service is provided.

## II. PURPOSE:

The purpose of this policy is to delineate, describe, and prescribe the procedures for the private insurance and self-pay/out of pocket clients.

## III. APPLICATION:

This policy applies to ACCESS staff, its affiliates, and contractors, who provide mental health or substance abuse services, supports and treatment on behalf of ACCESS.

## IV. PROCEDURES:

A. The Intake and Health Benefit Specialist
1. Will create the file in the EMR
2. Will document the client's benefits (Private Insurance or Self-Pay)
3. Assign the case to the physician, physician assistant
4. Assign the therapist – after reviewing the credentialing grid and consulting with the Supervisor
5. An appointment is provided for routine office visit within 10 working days
6. Authorization is obtained for the initial assessment
7. Consents are signed during the first appointment
    a. Financial Responsibility Agreement
    b. HIPAA Notice
    c. Consent for Treatment
    d. Consent to Share
    e. Release of Information/Coordination of Care

B. Co-Pays and Fees are collected before each appointment

C. The physician, physician assistant or therapist must perform the assessment, diagnose and recommend treatment

D. The following services are available for Private Insurance and Self-Pay Clients
1. Psychiatric diagnostic evaluation (with or without medical services)
2. Integrated Biopsychosocial Mental Health Assessment & Plan
3. Behavioral Health Assessment & Plan
4. Medication Review 10 min. E/M visit
5. Psychotherapy, 30 (16-37 mins)
6. Psychotherapy, 45 (38-52 mins)
7. Psychotherapy, 60 (53+)

E. Fee schedule for services available for Self-Pay Clients

| CPT Code | Description | Out of Pocket/Self Pay |
|---|---|---|
| 90792 | Psychiatric diagnostic evaluation (with medical services) | $ 150.00 |
| 90791 | Integrated Biopsychosocial Mental Health Assessment & Plan | $ 130.00 |
| 96156 | Behavioral Health Assessment & Plan | $ 130.00 |
| 90837 | Psychotherapy, 60 minutes | $ 100.00 |
| 90834 | Psychotherapy, 45 minutes | $ 50.00 |
| 90832 | Psychotherapy, 30 minutes | $ 25.00 |
| 99212 | Medication Review 10 min. E/M visit | $ 50.00 |
| H2030 | Clubhouse (15-minute units) | $ 4.25 |
| 96101 | Psychological Testing (per hour up to 6 hours) | $ 125.00 |

F. Fee Schedules for private insurances vary by the insurance

G. Mental Health Evaluation components

1. The Initial Diagnostic Evaluations and Mental Status Exam is to identify appropriate subjective and objective information pertinent to the patient's presenting complaint. The presenting symptoms are to be clearly identified with the onset, duration and intensity documented.

2. The assessments contain the patient's presenting problem(s) as well as relevant psychological or social conditions affecting the patient's medical or psychiatric status. For children and adolescents (18 and under), past medical history and psychiatric history includes prenatal and perinatal events and a complete developmental history (physical, psychological, social, intellectual, and academic).

3. The mental status exam is to document the patient's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, impulse control, suicidal ideation and homicidal ideation.

4. For patients 10 years and older, there is to be an appropriate notation in the assessment concerning past and present use of tobacco, alcohol, as well as illicit, prescribed and over- the-counter substances.

5. Past medical/behavioral history is easily identifiable in the record and includes, if applicable, previous treatment dates, former provider information, therapeutic interventions and responses, source of clinical data, relevant family information, results of lab test and consultation reports

6. To determine if a comprehensive substance use disorder (SUD) evaluation is needed, a SUD screening is to be incorporated into the assessment of all new patients

7. Additional assessments may be completed during the initial appointment or at any time during treatment

8. A Treatment Plan is developed by the service provider

H. Authorizations may be needed, and the provider must ensure that an authorization is in the system before services are provided.

1. Constant communication with the Intake and Health Benefit Specialists is a must in order to ensure reimbursements and insurance verifications are happening prior to service delivery
2. Notification to the Intake and Health Benefit Specialists team regarding follow up appointments is required, as some prior authorizations need at least 72 hours to be processed

I. Payments for Self-Pay clients, co-pays and deductibles will be received at the front desk at the time of check-in.
   1. If telehealth services are provided, payments must be processed prior to the appointment by phone

J. Managing a Psychiatric Emergency
   1. The patient may become aware of the danger his/her/their behavior poses (as with an overdose with the intent to die) or he/she/they may lack insight into the effects of their actions (as in the case of a manic patient who engages in reckless sexual behavior).
   2. Because of their lack of insight and judgment, patients in psychiatric emergencies are often brought to the attention of medical professionals by people in the community, including friends, family, police officers, or even bystanders.
   3. Providers may recognize psychiatric emergencies during routine outpatient care. Patients may report their inability to remain safe, either spontaneously or as elicited by the psychiatrist.
   4. When an emergency is recognized, the clinician/provider must:
      a. Perform a complete assessment of the concerning behavior
      b. Reduce risk by transferring the patient to an emergency department (ED) or to a psychiatric hospital as needed
      c. Provide or arrange for follow-up for continuity of care

K. Appointment Availability
   1. Non-life threatening emergent care within 6 hours
   2. Urgent care within 48 hours
   3. Routine office visit within 10 working days

L. Emergency Coverage
   1. The clinician makes arrangements for emergency coverage for all patients 24 hours per day/7 days per week
   2. Referral to Team Wellness at 888.813.TEAM(8326).

## V. QUALITY ASSURANCE/ IMPROVEMENT:

ACCESS Quality Assessment and Performance Improvement Program (QAPIP) must include measures for both monitoring of and for the continuous improvement in quality of the program or process described in this policy.

## VI. COMPLIANCE WITH ALL APPLICABLE LAWS:

ACCESS, its affiliates, service providers, and other contracted and subcontracted employees are bound by all applicable local, state and federal laws, rules, regulations, all Federal waiver requirements, and state and county contractual requirements, policies and administrative directives in effect, or as amended.

## VII. LEGAL AUTHORITY AND REFERENCES:

Agency Policies (All Agency Policies refer to the most recent at the time of writing)

## VIII. ATTACHMENTS:

a. Financial Responsibility Agreement
b. HIPAA Notice
c. Consent for Treatment
d. Consent to Share
e. Release of Information/Coordination of Care